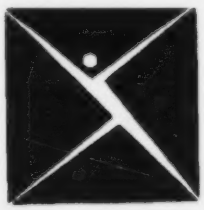
Mental Health Sector Study

Value of the Direct Voice –

The Role of Community Based Organizations in Delivering and Improving Mental Health Services in Saskatchewan



A Report of the
Canadian Mental Health Association
(Saskatchewan Division) Inc.

Researched and prepared by:

INNOVA Learning
Regina, Saskatchewan

With support from Saskatchewan Advanced Education and Employment and Saskatchewan Health

October, 2007

Executive Summary

During 2006 – 2007, the Canadian Mental Health Association, (Saskatchewan Division) Inc. in partnership with Saskatchewan Health and Saskatchewan Advanced Education and Employment undertook this study to examine the role for community based organizations (CBOs) in delivering mental health services in Saskatchewan. The study examined the current and emerging roles in which CBOs were involved, as well as the challenges to filling those roles. Related to this primary focus were issues pertaining to staffing, training, and the status of collaboration between CBOs and government and its agencies.

Information for the study was collected through three methods including a literature review of relevant documents as well as best practices, a survey distributed to 149 CBOs who provided some level of mental health support services, and in-depth interviews with 31 key informants.

CBOs were very certain about their role in delivering mental health services, specifically it focused on:

1. Providing direct service to individuals (adults) who were long-term mentally ill specifically social interaction, support, work/employment opportunities, and safe/secure housing.
2. Counseling and support services through individual and group sessions
3. Assessing and referring individuals to other agencies

An emerging role was providing education to both clients and the public through promotion and prevention activities. However, while they were certain of their roles, the future held many unknowns, in large part because of uncertain and insufficient funding to maintain existing programs, compensate current staff adequately, and ultimately recruit new staff.

The CBOs sector is experiencing a demographic shift which will likely see many of the senior staff in CBOs retire in the next 5 to 10 years. As these senior staff retire, so does their experience and expertise. The ability of CBOs to recruit senior staff with the professional expertise to lead and develop organizations was in question given the lower levels of compensation in the field and the competition from both the public health care sector as well as the private sector. All of these factors were of concern to the sector.

In spite of the difficulties and challenges CBOs staff faced on a day-to-day basis in delivering their programs and services, the level of commitment to their clients were considerable. But again, there was no certainty that CBOs would be able to continue this commitment in the future.

To maintain their current roles meant that much of the work CBOs felt that they should be focusing on, such as advocacy and engaging policy and decision makers, was reduced. In part this was because individual CBOs had limited staff and/or volunteers, as well as limited opportunities to collaborate within the CBO sector (because of limited funding and available staff) to research and develop the advocacy messages. At the same time there were limited opportunities to collaborate with government departments or Regional Health Authorities to address issues.

The concept of collaboration was well understood by the voluntary sector – many CBOs felt that it was difficult for individuals in the public sector to work collaboratively both because of institutional limitations, but also because it was a different way of operating for them. There was evidence of effective working relationships between specific groups of CBOs with specific parts of the public sector, but many of these relationships were highly dependent on the individuals directly involved. While it was hoped that such relationships would be seen as having long-term benefits to all organizations involved, it was questionable if the relationship would continue if any of the individuals changed. Organization-to-organization/sector-to-sector collaboration did not exist. There were few examples of best practices – specific to individual organizations (such as supporting staff to gain training) or relationships that had developed over time. As with collaboration, best practices depended on specific individuals.

Training and education for staff working in CBOs was an on-going frustration – there is no program of study that was sufficient to train individuals working in the human services field in mental health issues unless it was at a graduate level. In diploma programs and even undergraduate programs, concepts around mental health/illness were usually discussed as one topic among many in a specific course. Staffing for CBOs required a combination of professional staff (usually with an undergraduate degree) and paraprofessional staff (usually at the certificate/diploma level). While there was support for establishing the psychiatric nursing program, most CBOs did not feel that that program alone would provide them with the type of staff in CBOs needed. Furthermore there was the reality that most of the program's graduates would be working in the public health care system if salaries in the CBO sector continued to be uncompetitive. Providing continuing education opportunities for existing staff was also difficult – challenges included finding appropriate training that was cost-effective and readily available.

At the same time, without adequate and long-term funding, the future of careers and work in CBOs was difficult to plan for and to link training needs with shortages in the CBO sector. Human resource planning was a minor activity and consisted primarily of re-organizing work loads to address fixed funding for staff positions while overall costs increased. Planning for future positions was difficult without stable long-term funding; even determining when a position was vacant and should be filled was difficult if funding for the position was uncertain. Often the work of vacant positions would be distributed to other staff and volunteers or the program activities would be reduced.

CBOS were faced with:

- Compensation that was insufficient to support recruitment and retention of professionals/paraprofessionals to the CBO sector, particularly at a time when the public sector was also recruiting from the same pool of candidates,
- Funding constraints that did not support real programming costs,
- Limited staff numbers to address workloads and emerging needs to provide services to those clients and other individuals who cannot fully access current programs,
- Finding relevant training opportunities for staff, and
- Limited opportunities to support collective actions within the CBO sector.

If these issues were addressed, it would sustain and develop the role for CBOs as a direct voice for individuals and families who are experiencing mental illness as well as addressing prevention/promotion of mental health/mental illness.

Nine recommendations are identified in the report, including:

1. The province of Saskatchewan needs to develop a provincial strategy to address mental health and mental illness.
2. The primary role for CBOs should be support and rehabilitation/integration of mentally ill individual into the community .
3. Advocacy roles of CBOs must be supported.
4. Prevention/Promotion Services is an emerging role that CBOs should be actively involved in both developing and delivering.
5. Compensation for staff in CBOs must be addressed.
6. CBOs must be able to attract and retrain core professional staff
7. Expectations of CBOs by governments must be funded fully.
8. CBOs need support to sustain collective action.
9. A diploma level education program in mental health studies should be developed.

Purpose

The purpose of the study was to build on the work from the *Saskatchewan Mental Health Sector Study, Final Report* of 2002/2003, by focusing on the role of community-based organizations in the voluntary sector in the mental health sector.

The research focus examined the following:

- Current and future role(s) of community based organizations (CBOs) within the mental health sector and the barriers in fulfilling those roles,
- Current status of collaboration within the mental health sector, particularly the involvement of CBOs, and perspectives on lessons learned/best practices that support collaboration for effective service delivery,
- Perspectives on preparatory education for professional and para-professionals in the delivery of mental health services working within community based organizations, and
- Desired future for effective mental health services in Saskatchewan.

Context

Saskatchewan Mental Health Sector Study – Final Report

Saskatchewan Mental Health Sector Study, Final Report[1], known as "The Conway Report", focused on developing an overview and profile of the mental health workforce in Saskatchewan. In addition, the report previewed, discussed and offered recommendations on the issues, needs and gaps in the mental health system. The report was not intended to provide details on the role of the voluntary sector (including community based organizations) in delivering mental health services. However the report does identify several areas that suggest a role for the voluntary sector.

[1] Conway, John; *Saskatchewan Mental Health Sector Study, Final Report*, Mental Health Workforce in Saskatchewan, January 2003.

Conway notes the significant role reported by consumers in their recovery through the support they receive in their community from other consumers and from families and friends. The voluntary sector played a role by providing support for consumers, advocacy and support for families and friends, often through programs and services delivered through community-based organizations or other less formally organized support groups. Conway terms this approach to mental health delivery 'informal' care to differentiate it from the formal mental health system of diagnosis and treatment usually offered through Mental Health and Addiction Services of Regional Health Authorities. Regardless of the terminology, Conway was clear on the need for support for this informal system and that the need was as equally important as for support of the formal sector. Specifically Conway identified the need for ongoing support to develop and sustain the voluntary sector.

Conway identified two areas, primarily directed to adults, which community-based organizations currently contributed to mental health delivery – adult community services and psychiatric rehabilitation services. Services delivered specifically by CBOs, many which are funded through Regional Health Authorities, included:

- crisis services,
- case management,
- family support,
- vocational and recreational programs, and
- supported housing (usually in approved/group homes or apartment living options).

Conway also noted the role of other government departments in providing support for the voluntary sectors' contribution to mental health delivery – specifically programs provided through Community Resources (previously known as Social Services), Learning, Justice, and Corrections and Public Safety. All of these programs may link in some way to support an individual with mental illness to sustain the community supports needed, however Conway did not detail the specific interactions between the departments or how the programs supported individuals with mental illness.

While Conway identified needs and gaps in mental health delivery for First Nations and Metis People, any identified roles for CBOs in serving this target audience had a limited focus. In part this may be because of a shorter history of CBOs providing specific services in multiple sectors, not just mental health, to aboriginals. Consequently there was a limited number of CBOs who focused on First Nations/Metis and aboriginal people, and almost none whose focus was on mental health issues.

Driven by demographics, Conway identified the emerging and increasing need to address mental health issues in older adults. While not specifically describing a role for CBOs and the voluntary sector, the number of CBOs which focus on older adults is significant. How prepared and/or aware these CBOs were of an increasing trend towards older individuals with mental health issues was not known. Many of these organizations may need to prepare for changing and/or new service delivery as well as inter-organizational relationships to deliver appropriate programs.

A major focus of the Conway Report was profiling the professions and workforce delivering mental health services in Saskatchewan. Only minimal reference is provided to the staffing of CBOs – the focus was primarily on professional[2] positions, challenges in recruitment and retention, as well as training/education issues. As professionals, with regulatory/licensing requirements, this type of information was available. Few of these professionals were working in the voluntary sector. It was more likely that paraprofessionals would be working within the voluntary sector, but Conway's report did not delve into details. Paraprofessionals, while many have a common training requirement, because there is no regulatory requirement for licensing, little information was available on their status and/or working conditions in the mental health system.

While Conway noted the importance of the voluntary and informal sector in delivering mental health services, it was not the primary focus of his research. However, two areas stand out which are significant to this current study:

1. The importance consumers place on the support they receive in their community, of which some of this is through the voluntary sector, and in many locations in Saskatchewan, the majority of support may be provided through the voluntary sector, and
2. The need to provide support to the voluntary sector.

SAHO Study on CBO Compensation/Benefits

In the initial RFP for this project, a survey of compensation and benefits for staff in the community-based sector was identified. It is generally accepted that salaries, wages and benefits are lower in any CBO sector, not just those CBOs working in mental health delivery. However, while there is consensus that salaries are lower, no empirical data were available to support this assumption.

As this project was underway SAHO (Saskatchewan Association of Health Organizations) was tasked by SaskHealth with conducting a broader human resource study, which included compensation and benefits, for CBOs within the health care sector. The SAHO study, which began in April 2007, included contact with approximately 50 to 60 CBOs. The SAHO study will provide, through both a survey and interviews, an in-depth examination of:

- Number and type of positions
- Position descriptions and classifications
- Salary and benefits
- Qualifications, skills, and experience
- Vacant positions
- Recruitment and retention issues

Rather than conduct a parallel study, this project focused on the broader issues confronting CBOs in delivering mental health services. However some human resource issues affect the roles and services CBOs can assume and will be discussed in this report. As well the report examines the training options for paraprofessional staff in CBOs.

---

[2] Refer to the section, The Third Sector (Voluntary) in Society, for working definitions for professional and paraprofessional.

The SAHO study will tentatively be completed in November 2007. This report and the SAHO study are complementary reports. The SAHO study examines a smaller cohort of CBOs than this study, but with a focus on specific aspects of human resources. This study looks at the broader issues CBOs encounter in delivering mental health services. Both studies should be read together to gain a comprehensive picture of the CBO sector and mental health.

The Third Sector (Voluntary) in Society

National Initiatives

The voluntary sector has always been informally recognized as vital to developing policies, programs and services that improve and enhance Canadian society. The sector, often referred to as the 'third pillar' along with the public and private/cooperative sectors in the Canadian system, has been instrumental in the development of most of the public services seen as integral to a caring society – schools, hospitals, care for children, assistance to the disadvantaged, sport, cultural and recreational activities, etc.

During the late 1990's federal governments in many countries made a commitment to enter into active partnerships with the voluntary sector. In Britain, The Compact, with supporting Codes of Conduct, was adopted with the underlying philosophy that:

> '... voluntary and community activity is fundamental to the development of a democratic, socially inclusive society ... and that voluntary groups bring distinctive value to society and fulfill a role that is distinct from both the state and the market by enabling individuals to contribute to public life and the development of their communities.'[3]

In Canada, the federal government undertook the Voluntary Sector Initiative [4] with the aim to build the highest quality of life for Canadians. Specifically the commitment included examining the roles, needs, and future for the voluntary sector. While the voluntary sector was seen as an essential component in Canadian society, concerns existed including:

- accountability and governance issues (the Broadbent Report - *Building on Strength: Improving Governance and Accountability in Canada's Voluntary Sector, 1999*)
- recognition that support was required to help the voluntary sector fulfill increasing expectations from society to manage its resources and its work, and
- desire to develop collaborative partnerships between the public sector and the voluntary sector which recognized the significant role voluntary sector organizations have in developing and delivering services as well as advocating for a 'democratic, socially inclusive society'.

At the federal level, the focus was on multiple initiatives to improve understanding including:

---

[3] Home Office (1998), *Compact. Getting it Right Together*, London: The Stationery Office.
[4] PVSI, 2005, *Building a Collaborative Partnership between the Government of Saskatchewan and the Voluntary Sector: A Review of Best Practices.*

- Relationship building measures (reference group of ministers, coordinating participation within government, development of the Accord which sets out mutual obligations and benefits of the relationship)
- Capacity building measures (research on aspects of the voluntary sector - survey of giving, volunteering, funding policies and practices, awareness of the sector)
- Regulatory Measures (clarification of guidelines on allowable related businesses, access to public information on charities, director's liability, etc.)

Resulting from the Canadian government's initiative was:

- The Accord Between the Government of Canada and the Voluntary Sector, and
- Two Codes of Good Practice – one on Funding and one on Policy Dialogue.

The Accord committed the federal government to consider the implication of legislation, policies and programs on the voluntary sector and engage in open, informed and sustained dialogue. The Code of Good Practice on Policy Dialogue was intended to engage the voluntary sector in the public policy process so that policies were more reflective of Canada's diversity and responsive to needs. The Code of Good Practice on Funding called for funding arrangements to reflect the nature and scale of the issue at stake – for example, many social issues may require long term funding to make real progress. The Code encouraged federal government departments to build practices that supported:

- multi-year funding arrangements,
- clear and consistent communication around funding, and
- streamlined administrative, application and reporting procedures.

Overall the indent of the Accord and the Codes were to improve collaborative relationships between the sectors. However implementation of both the Accord and Codes were limited to a few departments and their interaction with specific organizations from the voluntary sector.

A recent development that specifically focused on funding in the voluntary sector is the report[5] of a Blue Ribbon Panel commissioned by the Treasury Board of Canada. The panel sets out four proposals that would significantly improve the funding mechanism and relationship between the federal government and the voluntary sector. The proposals include:

1. Respect the recipients – they are partners in a shared public purpose. Grant and contribution programs should be citizen-focused. The programs should be made accessible, understandable and useable.
2. Dramatically simplify the reporting and accountability regime – it should reflect the circumstances and capacities of recipients and the real needs of government and Parliament.
3. Encourage innovation – the goal of grant and contribution programs is not to eliminate errors but to achieve results, and that requires a sensible regime of risk management and performance reporting.
4. Organize information so that it serves recipients and program managers alike.

The report also noted the difficulty inherent in changing large organizations, particularly governments. Commitment and leadership was required by not only government officials,

[5] Treasury Board of Canada, December 2006, *From Red Tape to Clear Results – The Report of the Independent Blue Ribbon Panel on Grant and Contribution Programs*. Ottawa.

but by politicians and even the media to look at accountability through the lens of program performance rather than that of control. In addition to the leadership required at Treasury Board to ensure change, the panel also called for adequate resources including funding for people, training and tools to support change.

Provincial Initiatives

At the provincial level, Saskatchewan was the only province to establish a specific initiative, the Premier's Voluntary Sector Initiative (PVSI) in 2002 to build on the existing work at the federal level in developing sustainable relationships with the voluntary sector. Underlying the work of PVSI was the intent to, 'build on an effective and collaborative relationship between the Government of Saskatchewan and the Voluntary sector.'[6] With the emphasis of the PVSI on building collaborative partnerships to shape governments' interactions with the volunteer sector, the new paradigm focused on inclusiveness and collaboration. It moved away from the adversarial relationships between the two sectors to focus on respecting the complementary function of each.

However research has shown that while the intent was there to build collaborative partnerships, the reality and practice was difficult to achieve. Lessons learned[7] included:

- Changes in key players slowed down any process,
- Mistrust between sectors slowed process,
- If people didn't know about the initiative it could not be implemented effectively,
- Consultation was not collaboration, and
- Collaboration was not a way for government to control service delivery.

However, other promising practices that supported building the collaboration relationship included:

- Collaboration between government and the voluntary sector meant both came to the table as equal partners (who have different by equally important information to bring to the issue).
- Develop knowledgeable civil servants who understood and supported voluntary sector activities.
- Champions within government departments were needed to carry the message and win others over.
- Recognize that the process of building good working relationships took time (and funding).
- The process of working together was as important as the product in increasing understanding between the sectors.
- Balance autonomy and accountability.
- Build relationships on mutual respect and trust.

---

[6] The Premier's Voluntary Sector Initiative (2002). *A Framework for Partnership Between the Government of Saskatchewan and Saskatchewan's Voluntary Sector.* Regina: Government of Canada.

[7] PVSI, 2005, *Building a Collaborative Partnership between the Government of Saskatchewan and the Voluntary Sector: A Review of Best Practices.*

The 2006-2007 Workplan[8] for the PVSI identified several directions which address some of the barriers and could serve as a foundation for the voluntary sector in the mental health system. From government, plans included:

- An annual meeting with Human Services Deputy Ministers to report on progress, identify issues and discuss future priorities for action.
- Begin work with the voluntary sector on a better understanding of the funding mechanism used by government departments
- Plan and conduct the annual forum as well as policy conferences to ensure that senior leaders in government departments and sectors are aware of the issues affecting the relationship and the potential role of the PVSI in addressing these issues.
- Work with Regional Intersectoral Committees on an inventory of capacity building supports that exist and identify future needs based on their understanding of community supports and activities of the informal agencies that operate in the community, and
- Work with the Crossing Boundaries Initiative[9] to link the voluntary sector to efforts in the public sector to improve service delivery through a user-centered approach and more effective use of technology.

Representatives from the voluntary sector on the PVSI Steering Committee were encouraged to work to improve the effectiveness of relationships within the sector using the principles and values in the framework document to lead to a set of expectations for the voluntary sector that would be parallel to the expectations of government departments.

Summary of National/Provincial Initiatives

With the exception of the Blue Ribbon Panel, the change in the government at the federal level has created some uncertainty with the status of the Voluntary Sector Initiative. However a recent tender was released to develop an evaluation framework for the Community Sector Strategy so some work continues at the federal level in working with the voluntary sector. At the provincial level, the work of the PVSI continues, but its future may be uncertain with an impending provincial election within the next 12 to 18 months. However, while reports have been produced and intentions stated, few actual results have emerged that have significantly changed the operating environment for organizations in the voluntary sector.

Terminology

One of the continuing difficulties confronting researchers studying the work of community-based organizations is the varied and, at times, changing terminology used within the sector. This study found similar issues which often needed further explanation to confirm concepts. There were primarily two areas that needed clarification:

- Professional vs paraprofessional occupations
- What is a community based organization?

---

[8] PVSI Update, 2005 (available at http://cyr.gov.sk.ca/assets/pdf/VSI/Premiers_Report2005.pdf)

[9] Crossing Boundaries is a not-for-profit national forum whose mission is to foster the development of Canada as an information society through more citizen-centred approach to government and governance. The project began almost a decade ago and has since been through four iterations, the most recent of which was the Crossing Boundaries National Council

Professional

For the purposes of this study, the following terminology was used to define professional and paraprofessional.

A professional was deemed to be any individual working in an occupation which required a licensing or regulatory body (including self-regulatory bodies) to confirm education/credentials/experience **and** to authorize the individual to practice in the profession. In the health sector there are 26 provincially self-regulated health care professions, ranging from physicians to nurses to dental hygienists. Other self-regulated professions may work in the health sector, such as social workers, but are regulated by legislation through other government departments.

While an individual may hold professional standing, it does not mean that he/she would be working in the regulated profession. However, not working in the profession may, at some point, result in his/her professional designation being withdrawn or denied.

Paraprofessional

Paraprofessionals encompass a variety of occupations in which there may be a common educational or training component, either acquired formally through a post-secondary educational institution or through on-the-job training. While there is a common training component, there is not a licensing requirement or a regulatory body which deems who can, or cannot, work in the occupation.

Employers may have preferences for individuals who have acquired a specific set of educational qualifications, but having such educational qualifications is not a requirement to work in the occupation. Many of these occupations will have associations (such as the Saskatchewan Association of Chemical Dependency Workers) which inform and provide continuing education to their members, but these organizations are not licensing/regulatory bodies. However with the increasing trend toward 'credential creep', many of the paraprofessionals occupations cited in this study may be subject to some form of licensing or certification in the future.

As noted in the Conway Report, occupations relevant to the care of the mentally ill and which generally are considered paraprofessional, include:

- Continuing Care Aide (formerly Home Care/Special Care Aide)
- Addictions Counseling (formerly Chemical Dependency Worker)
- Correctional Studies (formerly Corrections Workers)
- Early Childhood Education Worker
- Rehabilitation Worker
- Occupational/Physical Therapist Assistant (*Program been suspended and applications are not currently being accepted. A review of the program's graduate employment statistics reveals that there has been a decline in the number of available training-related opportunities for graduates, particularly full-time positions)*
- Youth Care Worker

Community Based Organizations

The second area of terminology centered on what constitutes a community-based organization. Some of the confusion stems from the continuing movement to devolve and deinstitutionalize services from public agencies and governments into the community. The result is that service from government and their public agencies may be provided 'in the community' as opposed to in an institution, but the government or public agency providing the service is not a community-based organization. The control of the program and service continues to reside with the associated public agency. For example, it is unclear in *Out of the Shadows* about what type of agency would deliver the vision of community care advocated in the report.

Ten to fifteen years ago, the more common term used was non-governmental agency (NGO) which made a clearer separation from government and their related agencies. This term is still used in many provinces and by individuals in some organizations. Additional terms include non-profit organizations, not-for-profit organizations, and charitable organizations. Again, the location seems to determine the use of terms; for example in Alberta, the government refers to CBOs as non-profits and the term 'community-based organization' has little meaning in government departments. Similarly in some Saskatchewan government departments, such as Community Resources, the term CBO is very common – in other departments, likely because they have limited involvement with the voluntary sector, CBO is an unknown term and the voluntary sector is seen only as individuals who volunteer.

Again, for the purposes of this study, community-based organization (CBO), which will include NGOs and non-profits, are defined as:

> *Independent organizations with a volunteer board of directors elected from the community; typically the CBO provides services, represents and advocates for the needs of a specific target audience. While the CBO may receive funding from government departments to deliver services, they do not exist only to deliver a service for government or related agents of governments; decisions regarding directions, programs and/or staffing are at the discretion of the CBO.*

All CBOs will be not-for profit – in that any revenue through grants, fundraising, donations will directly benefit and sustain the work of the organization rather than to increase the wealth of specific individuals to share from excess revenue over expenditures (such as profit sharing plans or earned bonuses). However, most CBOs find that they need to fundraise more in order to cover operational costs, including such basics as staff salaries and overhead costs.

However, not all CBOs will be charities. Charitable status is at the discretion of the Government of Canada (Canada Revenue Agency) and only after a review of the mission/mandate of the organization, and how it uses its resources to achieve its mission/mandate. Most CBOs will seek charitable status to facilitate fundraising and donations; however is it not a requirement.

Another term has emerged which reflects the increasing hybrid look to the voluntary sector - quango[10]. Quango's are:

> *Quasi-nongovernmental organizations including schools, colleges/universities, hospitals and public infrastructure, usually established through a specific act of government. Such organizations may have Boards of Directors, however often some members (and it may be a majority) of the board are appointed by government. Many may make extensive use of volunteers, but their authority to act and as well as their scope of activities rests with the specific piece of legislation.*

In Saskatchewan, there is dual terminology embedded in legislation governing Regional Health Authorities – that of HCOs (health care organizations). Many HCOs are CBOs, but fall under the definition of HCO used in legislation for Regional Health Authorities. This only adds to confusion in discussing the roles of CBOs in the delivery of mental health services, as most staff in Regional Health Authorities may only have relationships, usually based on funding, with HCOs and may or may not recognize that the HCO is also a CBO.

Another confusing issue for government and government agencies is the role of staff in CBOs. Many CBOs will have staff, but having staff does not exclude them from being part of the voluntary sector. The degree to which a CBO receives funding from government departments will vary depending on the needs of their target audience and the types of services provided to the target audience. Some CBOs will have a relatively small staff component, which may focus on coordinating volunteer activity, or there may be a larger staff component comprised of professionals, paraprofessionals and volunteers – all delivering programs to targeted audiences. As well, many CBOs do not differentiate between their paid staff and their volunteer staff. However, the direction of programs and the organization, which are implemented by staff, is through the governance and role of the volunteer Board of Directors.

Formal accountability of CBOs is through the public mechanism of annual general meetings, but as well as through the Non-Profit Corporations Act, administered by the Corporations Branch of Saskatchewan Justice which requires annual reporting. However the ultimate accountability for any CBOs rests with its reputation and perception within its community – a reputation that includes providing a valued service which is addressing a need in the community, and benefits the community and those who live there.

Governments and CBOs

Working with CBOs is difficult for governments – no two CBOs, even those working within the same sector, will have the same perspectives on a situation, the same governing/decision-making structures, and/or the same capacity to act. On the other hand, government, and its agencies such as Regional Health Authorities, is designed to deliver public programs in a uniform manner (so that the public perception is one of

[10] Calgary Chamber of Voluntary Organizations (2006); *Human Resources Issues for Alberta's Nonprofits*, 2006

fairness). This will often conflict with CBOs, which are quite use to changing programs and services to meet needs which emerge in their community. This often results in contradictions, for example, when service contracts signed 12 to 18 months previously to deliver a service are being implemented differently because the needs of the target community have changed. The government's role is to ensure accountability through implementation of the contract, while the CBO feels it is filling its mandate by responding to needs in the community.

In addition for many CBOs their history of service provision is, in many cases, as old as the government's. For example, YWCA Regina was established in 1911, while the YWCA Saskatoon was established in 1910, when the province itself was less than 5 years old. The YMCA of Regina was offering services in 1890. These organizations' mandates have not changed substantially since their inception, although specific programs may have. Similarly what is now Family Service Regina was established in 1931, before many of the social support programs now embedded in government departments even existed. So the question is asked, in good faith, by CBOs – who has the more expertise in not only identifying needs, but in developing and delivering services to the community?

This way of thinking was central to the work done by governments through the various voluntary sector initiatives, specifically around the issue of collaboration. Both sectors were bringing resources (such as experience and information) to the table in order to address issues that were too complex and broad for any one organization to deal with successfully. Both sectors needed each other – the voluntary sector had a depth and wealth of experience with the needs of the target audience, but not necessarily the resources or power to act, whereas governments had the resources and power to act, but not necessarily the direct connection to the target audience.

Working Together Complicates the Process

A more recent development, in part emerging from the work of the various voluntary sector initiatives has seen the development and push for CBOs to work in partnerships, coalitions, collaborations, cooperatives, etc. to address complex social problems. The ideal is that by working together, more can be achieved than by working alone.

However, this has also lead to more complex organizations, such as a coalition working to end hunger, which become entities separate from each of the individual member organizations of the coalition. These hybrid organizations can blur an already complex range of service delivery mechanisms, as well as communication and control systems.

However, the major difficulty is the sustainability of such coalitions. In most instances, coalitions are in addition to the workload of staff/volunteers in their own organizations. Consequently the existence coalitions can be jeopardized if staff cannot commit sufficient time to devote to the work of the coalition – a lot of time can be spent meeting but with few results. Financial support to carry on the work of a coalition is critical – rarely can individual CBOs provide support for coalitions from their existing budgets. The ideal of a coalition may be positive in creating forums for joint action to address common issues and may be attractive to government departments and agencies as an entry point to "talk" to

common interest groups in the voluntary sector, but without external funding, coalitions are difficult to sustain.

Methodology

The approach used to collect data for this study included three main sources of information:

1. Literature review
2. Interviews with key informants
3. Survey to CBOs providing mental health services.

The primary focus of the study was on community-based organizations not on the individuals who use the services of these organizations. That is not to diminish the views and experiences of individual consumers/users of CBO services, but to include that target audience in this project was beyond the resources available. However, CBOs do actively represent these individuals – often consumers are represented on boards and through other mechanisms within CBOs (such as Consumer Advisory Committees or residents groups).

Data Collection

Literature Review

The literature was in two parts – first to become familiar with the scope and state of the field and included reviewing reports such as:

- Saskatchewan Mental Health Sector Study – Final Report (John Conway, 2002)
- Working Together – Saskatchewan Health Workforce Action Plan
- Canadian Collaborative Mental Health Initiative publications (Collaborative Mental Health Framework, Review of Canadian Initiatives, Strengthening Collaboration through Interprofessional Education, Health Human Resources in Collaborative Mental Health Care.)
- Human Face of Mental Health and Mental Illness in Canada, 2006
- Framework for Support (3rd Edition), CMHA
- Mental Health Priorities of the Voluntary Sector (Citizens for Mental Health, CMHA)
- Out Of The Shadows At Last - Transforming Mental Health, Mental Illness and Addiction Services in Canada

This review provided both tentative directions for further information as well as identified key issues to address during interviews. As the interview data was analyzed, an additional literature review was conducted to seek out supporting or alternative views of what was being said in the interviews.

While the Conway Report did a comprehensive review of the education/training for professional positions in the mental heath system, little attention was paid to the para-professional positions. This study reviewed the current curriculum for many of these occupations, with a specific reference to the content pertaining to mental health issues.

Key Informant Interviews

Key informant interviews were conducted with 31 individuals – each interview lasted 1 to 2.5 hours, and examined the role of the organization and its challenges. Interviews were conducted with CBOs, professional organizations, Directors of Mental Health Services, and post secondary education institutions. Given the scope, resources and purpose of this study, a statistically valid sample is neither possible nor needed. Rather, a purposeful sample[11] was used. Purposeful sampling selects specific individuals/organizations (key informants) because they can provide information that expands the knowledge of the situation or problem.

Content for the interviews included from:

i. Mental Health and Addiction Services (Regional Health Authorities)
   - Understanding roles for CBOs/HCOs and well as expectations for CBOs in the delivery of mental health services
   - Perspectives on collaboration

ii. CBOs (including both HCOs directly funded by Health Regions and non-funded CBOs)
   - Current roles as well as restrictions/limitations to existing roles/new roles.
   - Status of collaboration with other CBOs, RHAs and government departments, and
   - Staffing issues

iii. Post Secondary Education Institutions
   - Approach to mental health issues in program content as well as collaboration/role for community based organizations in service delivery.

iv. Professional Associations
   - influence on preparatory training/continuing education on
     1. mental health/illness context/topics
     2. understanding of collaboration and the role for community-based organizations.

v. Staff from selected best practice projects from Canadian Collaborative Mental Health Initiative – projects needed to involve community based organizations.

Interviews were confidential and semi-structured; a semi-structured interview allows for unanticipated responses to emerging issues and is appropriate for investigations where information on the state of the field is limited. Where possible interviews were conducted in-person, however some were done by telephone.

Up to four different interview schedules were developed because of the focus of each interview – some interview schedules contained similar questions, while other questions were different depending on the focus of the organization. As well, as each interview progressed, interviewees identified areas that were of specific concern to their organization – this information not only provided the unique view sought in key informant

[11] Bogdan, Robert C. and Sari Knopp Biklen; *Qualitative Research for Education: An Introduction to Theory and Methods*, Boston, 1982

interviews but also provided additional questions to ask of future interviewees to confirm or alter emerging perspectives.

Survey

A survey was distributed to 149 CBOs during February 2007 – the survey could be either faxed back or returned in a pre-paid envelop. In the introduction to the survey, respondents were informed that their responses would be confidential and would be used in aggregate format.

The list of CBOs was complied from seven sources including:

- United Way funded organizations (and similar cooperative community funding raising organizations in various communities)
- HCOs listed in Regional Health Authorities Annual Reports
- U of R Faculty of Social Work Practicum Sites
- Mental Health Coalition members
- Volunteer Regina members list
- Connections Service Directory (supported through the Government of Saskatchewan)
- Suggestions from individuals, usually through interviews.

In selecting CBOs for the survey two criteria were used:

- their target audiences had to be 'at-risk' of developing or had mental health problems, such as CBOs dealing with victims of domestic violence, and
- they had to provide some level of counseling or support service.

Furthermore, the aim was to identify organizations which were distributed throughout the province, not just the major centres of Regina and Saskatoon. As well, because mental health crosses numerous sectors, the organizations were also chosen to reflect a diversity of organizations such as health, education, justice, and social services. A complete list of organizations receiving the survey is available in Appendix 1. The survey is attached in Appendix 2.

Consideration was given to including religious organizations because of the focus of pastoral care is often on mental health issues, however given the scope and resources of the current project, that group was excluded from the survey. However, any future directions emerging from this study should aim to be inclusive with this target audience as they are often one of the first contacts made by individuals attempting to resolve a mental health concern.[12]

The focus of the survey was to determine the degree/extent this group of CBOs dealt with mental health issues with their clients, resources available to them, staffing issues, as well as relationship with their Regional Health Authority around mental health services.

---

[12] Personal conversations with a minister and priest confirmed the role and frequency that they deal with parishioners who are having mental health issues personally or within the family – neither individual was comfortable with counseling and most often referred these individuals onto other agencies including family doctors, mental health clinics and/or family service bureau. However both were extremely interested in having a greater understanding of the mental health system and the potential role for the clergy.

Data Analysis Process

A goal of this project was to not only identify, but also to create understanding of the role of CBOs in mental health delivery and the barriers and practices that are supporting this role. The use of in-depth key informant interviews contributed to creating this understanding, along with literature review and the survey.

Key Informant Interviews

Qualitative data obtained through key informant interviews was analyzed through inductive analysis. Inductive analysis seeks to develop concepts or ideas through a systematic examination of similarities. As evidence accumulates, comparisons establish similarities and differences among incidents or situations to help define categories and concepts. Inductive analysis also pays attention to evidence that challenges or disconfirms whatever similarities are developing. Inductive analysis requires progressive redefinition of the situation and the explanatory factors. It is through this process that understanding and meaning from the perspective of the target population is created.

With inductive analysis, there is no methodological value in piling up additional interviews, but rather the approach seeks encounters with new varieties of information in order to force revisions to make the analysis valid when applied to an increasingly diverse range of cases.

Survey

Number data from the survey was tabulated for further analysis, while work data was analysed through a modified inductive analysis process. However caution should be used in interpreting the number data from the survey. While the response rate of 39% was good, absolute numbers are still small. This is the nature of the target audience – there are a relatively small number of CBOs delivering a very specific service, that of mental health.

Conclusions were draw from integrating data from all sources. The literature review was incorporated into the key informant data analysis to provide both support for positions expressed as well as alternatives for consideration. Number data from the survey was tabulated, presented and discussed within the context of the literature review and key informant interviews.

Tabulating word data from both key informant interviews and open-ended questions on the survey to reflect a number is generally not an appropriate method of analysis given the nature of word data. This is particularly true for key informant interviews where individuals are selected because of the specific knowledge they have of a situation – knowledge that may only be available from a few individuals. However as a general guide, the following terms[13] have been used to reflect the prevalence of responses:

Most: views expressed by a majority of respondents

Some or a few: views expressed by a small number of participants.

---

[13] Hall, Michael, et al., *The Capacity to Service: A Qualitative Study of the Challenges Facing Canada's Non-profit and Voluntary Organizations*. Centre for Philanthropy, 2004

Limitations to Study

There were two limitations to this study. The first limitation was that there is no single reference group or association that represents mental health workers in community based organizations. Consequently information on employment and training needs of staff in the CBO mental health sector is scattered. There are provincial licensing bodies and professional associations, however few deal primarily with mental health issues. Furthermore, few of their members work within the CBO sector. At the paraprofessional level, provincial associations represent the entire scope of workers in the field not just mental health. While there may be members of these associations working in mental health organizations, the focus of these organizations is not the employment and training needs of individuals working to deliver mental health services through the CBO sector.

The second limitation to the study of the role for CBOs in delivering mental health services goes beyond CBOs defined as HCOs. While it would be easier to address just the roles for CBOs that are also HCOs, a more complete picture of the human resource was needed to identify the roles of CBOs in delivering mental health services, beyond the contractual services of HCOs. However in doing so, the picture becomes more complex as organizations are diverse.

Summary of Findings

Survey Results

The survey was distributed to 149 CBOs. Six surveys were returned with an unknown or undeliverable address for a total sample of 143. Of the 58 surveys returned, two indicated that they provided no mental health services[14]. A useable sample was 56 completed surveys out of 143 for a return rate of 39%

Organization Profile

When selecting organizations for the survey, general information on their structure and governance was reviewed. To confirm if the organization was a CBO, a question was included to confirm there status as a CBO. All 56 organizations responding to the survey indicated that they did consider themselves to be a CBO as defined in the survey.

Of those organizations responding, 66% (37 organizations) indicated that at least half or more of their organization's focus was on addressing mental health problems/issues of their clients, even though many noted that mental health was not the primary mandate or mission of their organization. Five organizations (11%) indicated that less than 25% of their organization's focus was on mental health issues, although many of these noted in comments that their staff or volunteers were expected to know about where to get help if a client was seeking help for a mental health problem. One organization indicated that this

[14] However, one of the two provided a description of their programs and services which included counseling for stress and depression as well as referring individuals to other organizations for service. However as the survey questions were not completed, this organization was not included in the analysis.

was a problem for them because they were in a very rural community and the mental health clinic through the RHA was at least a two hour drive.

Respondents were asked to describe the three major roles that their organizations had in providing mental health services, these included:

1. Counseling – both individual and group sessions (47 organizations)
2. Assessing and referring to other agencies (37 organizations)
3. Providing education to both clients and the public (33 organizations)

Providing services, such as residential housing and/or vocational training/rehabilitation, was indicated by only a few of the organizations as it is a specialized service generally provided by HCOs under contract to Regional Health Authorities – the survey extended beyond this limited pool of CBOs.

A fourth area in which 21 organizations indicated they provided services was in advocating/assisting individuals to get the appropriate service for their needs. One respondent indicated, *'...my staff and I spend an inordinate amount of time in trying to connect individuals who need mental health services to the right agency, organization or government department – many of which are out of our community – it is not just getting them an address or a name, we often need to take them there and make sure they get an appointment to see someone."* CBOs acted as a liaison between their clients, who had mental health issues, and other government departments, often around income support and earned employment income issues.

Many organizations commented on the 'silo' effect that seemed to still exist between government departments – if a client received service or funding from one government department or one part of a government department, then another government department did not need to provide service to the client. This is of particular concern for issues involving mental health because mental health problems impact multiple areas in individuals and families lives, including employment, education, housing, income support, recreation, health and at times, justice. It is possible that an individual or family may be having to deal with multiple government departments to access a viable set of services.

Some respondents noted that over the years this had got better, but it largely depended on the individual government staff as well as locations (offices). The situation also extended to the funding of the CBO itself; *'We are a domestic abuse shelter and while many of our clients do have mental health issues because of the abuse, they are not mentally ill. However it is not uncommon for the hospital to call us to take a long-term mentally ill woman in for shelter, because nothing else is available. We do it, but we are not funded for that and our staff are not trained to help this woman. And then we get in between the RHA, Health and Community Resources over who should fund this – doesn't help us and doesn't help the woman either."*

Respondents were asked to indicate approximately the number of individuals their organization delivered services to in the last year – a total of 63,624 individuals were served by the 56 organizations responding (an average of 1, 136 per organization). For some, the number was as low as two (but required intensive service and interaction because of their needs); while for one it was as high as 20,000 because of their 24 hour

crisis line. These organizations provide a significant resource for individuals seeking help – in some cases respondents noted that they may be the only organization doing so in a small community.

Staffing

The 56 organizations responding to the survey reported 924 full and part-time staff including contract or project staff. Of the total number of staff, respondents were asked to indicate the number of staff who spent a significant amount of their work time delivering mental health services – respondents indicated that 332 of their staff did so. Of these staff almost 161 were full-time staff members. For comparison purposes, in 2004-2005 there were a **total** of 719.5 mental health **and** addictions staff in all of the Regional Health Authorities[15].

Twenty six organizations (47%) indicated that they did not use volunteers to deliver their programs or services (the only volunteers were members of their Board). One respondent indicated they did not use volunteers, *'... not because be don't have people who want to volunteer and would be good, but we don't have the staff to develop, train and monitor the work of volunteers. So we have decided, at this point, it is not a good strategy. However we are constantly seeking funding, even for a ½ time position – this would allow us to meet the demand from our community for presentations, information, just having a voice that answers the phone rather than a machine taking messages."*

The remaining 30 organizations indicated that 893 volunteers committed time to deliver some aspect of mental health services. The number of hours committed was 23,072 over the last year (or the equivalent of 623 weeks of full-time work).

Funding Sources

Identifying funding sources is often complex and difficult since many CBOs rely on multiple sources with funding attached to specific projects or programs. Respondents were asked to focus on the positions which provided significant mental health services and to identify the percent of funding from a list of sources. Table 1 indicates the source of funding for programs/services.

Respondents indicated, on average, 14% of their funding came through federal government departments, while 59% came from both the provincial government departments (42%) and regional health authorities (17%). For seven organizations, 100% of their funding came directly from one source, while 12 organizations indicated two sources. Given that health care is primarily a provincial responsibility, that almost 60% of funding coming from provincial sources is to be expected. However 27% of funding is coming from non-governmental sources - 18.5% was generated directly (through funding raising, fee for service etc.) by CBOs themselves.

---

[15] [15](Mental Health and Addictions Services, 2005: *Cross Cultural Needs Assessment, Provincial Cross Training Initiative.*

Table 1: Source of Funding for Programs and Services

42 %	Provincial government departments
17 %	Regional Health Authorities
14 %	Federal government departments
12 %	Self generated (donations, fundraising events)
6.5 %	Fee for service (client and/or employer pays such as EFAP)
4 %	Community (foundations, corporations, etc.)
3%	Other (not described)
1.5 %	Municipal governments

Staffing Issues

Respondents rated, on a scale of 1 to 5, the difficulty of recruiting and retaining qualified staff. Forty organizations (72%) indicated that it was either difficult or somewhat difficult to recruit staff; 34 organizations (61%) responded that it was either difficult or somewhat difficult to retain qualified staff in their organization.

Respondents were asked to describe the major problems they encountered in recruitment and/or retaining staff. Five common problems were identified:

1. Non competitive salaries/wages/benefits were cited by 51 organizations. Specifically the competition was coming from the public sector – either government departments or quango organizations such as Regional Health Authorities. But in some locations competition was coming from the private sector (not necessarily health or other CBOs, but rather retail outlets because of local labour market demands). As the nature of the work in many of the CBOs required shift work or overtime, many respondents were not positive about the future of their organization to recruit qualified individuals.
2. Applicants did not have any background in mental health, even those with a university degree or college diploma/certificate (cited by 47 organizations). One respondent noted, *"I hired someone with a university degree who had at least taken an abnormal psychological course – she lasted three weeks, because the clients were not what was described in her course."*
3. Thirty-seven organizations indicated that they were a training ground for new graduates. Respondents noted that they knew the individuals recruited were using the position as a starting point and would move on after gaining experience – often to the public sector where wages and benefits were much higher. But because of their need for staff, they were willing to hire these individuals in the hope that they might stay at least a year or two.

4. Burnout, stress and workload was high not only because of the nature of the job, but because of the hours and the low wages (these issues were cited by 38 organizations). Retaining staff in this type of situation was an on-going challenge. One respondent noted that *"....about five years ago we almost had enough staff, but with increases in overhead costs, that no government wants to cover in our annual contract, I had to reduce a position to half-time and then last year the position went completely – but guess what? – the funder still wants the same contract with all the same work!"*
5. Thirty-one organizations cited that no job security for staff was a problem. Even positions designated as permanent were not and respondents indicated that every year they were not sure which positions would be funded. Consequently staff were constantly looking for full-time permanent work – often not in their field of interest or training.

Table 2 shows respondents preferences (through rank-order with 1 being the most important) for qualifications for entry-level positions

Table 2: Preferences for qualifications for entry-level positions

1 Bachelor's degree in a mental health area (cited as a first preference by 14 organizations)

2 Diploma (two years) in a mental health area (cited as a first preference by 12 organizations)

3 Bachelor's degree in a related area, plus additional training in psychiatric rehabilitation (cited as a first preference by 11 organizations)

4 High school diploma plus training in psychiatric rehabilitation (cited as first preference by 10 organizations)

5 Master's degree in a mental health area (cited as a first preference by 4 organizations)

6 Certificate (one year) in a related area with additional training in psychiatric rehabilitation (cited as a first preference by 4 organizations)

7 Other (usually indicated someone who was accepting of the organization's clients and their needs), cited as a first preference by 1 organization.

Just under half of the organizations (27 organizations) indicated preference for staff who did not have a university education.

Many respondents noted that the ranking was an 'ideal' and with the current labour market situation they were realistically looking for individuals who were willing to commit and learn on the job (which may explain the relatively high ranking for a high school diploma with training in psychiatric rehabilitation). The low ranking for a master's degree in a mental health area was rated as the most important for CBOs whose focus was exclusively on counseling/therapy, such as family service bureaus.[16]

[16] This group of organizations is relatively few in number and only 4 organizations responded to the survey.

On-the-job training was a significant factor for survey respondents, however many acknowledged that they did a poor job of providing training, primarily because, *'we don't have the staff to provide on-going training or the money to develop a program that we could implement in-house.'*

The top three qualifications were very close (only five or six organizations separated the rankings). However comments included:

> *"I would love to be able to recruit someone with a degree in a mental health area, but it doesn't exist (or I haven't found one) and we would never be able to afford to pay them."*
>
> *"BSW degrees are a good start, but we have to put so much training into getting them to think 'outside of their course work" that it sometimes is not worth it – I would rather take someone who has a high school diploma, a good and caring attitude and is willing to learn, than to untrain a university graduate."*
>
> *"We are in a rural location which is hard enough to recruit given the wages that we offer and the long hours of work – we need university graduates to be able to 'talk' with the regional health authorities, but I can't recruit or keep them more than one or two years."*

One respondent was very clear on their organization's needs,

> *"... someone with some post-secondary education, but I need to be able to send them off to a 2 or 3 day training module or a series of modules that focus specifically on the range of mental health, mental illness and the various approaches to support mentally ill individuals. I looked at some university courses, but they were not offered at a distance or only over an entire semester and the content was really not appropriate for trying to integrate clients back into the community. As well, that delivery system doesn't fit our needs for staffing and keeping our organization operating on a day-to-day basis. We are sometimes able to take advantage of training that the RHA offers, but they seem to be hit and miss about informing us what is coming up and I often hear of training that would have benefited some of our staff after the fact. I know training us is not their responsibility, but it just helps."*

Respondents were also asked to rank the challenges that they anticipated their organization would need to address within the next five years (with one being the most challenging). Table 3 lists the results – the number one challenge (reported by 52 organizations) was maintaining current level of program/service delivery, which is consistent with previous concerns regarding funding levels and recruiting qualified front line staff.

Succession planning was ranked as number two (reported by 49 organizations). CBOs in almost all sectors throughout Canada have an aging workforce that will be leaving within the next 5 to 10 years[17]. This situation also extends beyond CBOs into the profit and public sector, however in these sectors there are generally more resources available to

[17] Calgary Chamber of Voluntary Organizations, *Human Resources Issues for Alberta's Nonprofits*, 2006.

identify options and implement solutions.[18] When this segment of the workforce leaves, so will their experience in the content, programs and the management of CBOs. Combined with funding challenges, compensation that does not reward the expertise and workload, succession planning is made even more difficult.

Table 3: Rank order of Challenges CBOs anticipate in the next five years

1	Maintaining current level of program/service delivery
2	Succession planning (replacing senior staff in our organization)
3	Recruiting front line staff
4	Promoting knowledge about mental health to the public
5	Using best practices to develop mental health programs and services
6	Developing advocacy positions to enhance mental health services
7	Developing programs/services to respond to emerging mental health issues in our community

Although many CBOs have stated advocacy as part of their mission/mandate, it ranked low with this survey group – one commented, *"I know we should be doing more advocacy to influence government policy, but we don't have the time to commit to this, and more importantly we don't have the staff with the skills to do the research. We rely on our Board, but their time is stretched – I feel ashamed at rating it so low, but that is what it is and I don't see it changing. The government is being let off the hook because we are not doing this, but I either deliver the service I'm being contracted to or spend time on developing advocacy – that's a no brainer."*

Relationships with Regional Health Authorities

Respondents were asked to rate their relationship with the mental health services offered through their Regional Health Authority, using a five point scale of 1 (poor) to 5 (excellent). Five questions were posed to respondents that focused on areas of communication, working together and mutual understanding of programs and services – generally considered the essentials to establishing cooperative and/or collaborative initiatives[19]. Table 4 shows the results – 39% of respondents (22 organizations) indicated that open formal communication was poor or insufficient, while a similar number indicated that it was good to excellent.

In general, those CBOs which rated their relationship as good or excellent with the mental health services through the Regional Health Authorities also had long-term funding relationships with them. However, several of these respondents also indicated that the relationship was based solely on individual-to-individual contact. When the individual contact left the RHA, there was little, if any, continuity and the CBO needed to start from the beginning to inform the RHA of what the CBO did (and did not do). As one

[18] Parker, Owen, *Organizations Failing to Prepare for Aging Workforce*, InsideEdge, Volume 10, Number 4, 2006; Conference Board of Canada

[19] Taylor Powell, E. Rossing, B. & Geran, J. (1998); *Evaluation Collaboratives – Reaching the Potential*, Program Development and Evaluation; University of Wisconsin (Exension)

respondent commented, *"Our relationship was good up until about two years ago when there was a change with the department head – it has gone downhill from there – but I think that person is due to move into another position, so it could change again."*

Table 4: CBOs' perception of their relationship with Mental Health Services through RHAs

Response Question	Poor/Insufficient	Average	Good/Excellent
There is open formal communication between our organization and the Regional Health Authority about mental health needs in our region.	39% 22 organizations	26% 15 organizations	35% 19 organizations
There are opportunities to work collaboratively with the Regional Health Authority to develop programs to address mental health needs in our region	44% 24 organizations	23% 14 organizations	33% 18 organizations
There is a common commitment to address problems identified in delivering mental health services with the Regional Health Authority.	42% 23 organizations	28% 16 organizations	30% 17 organizations
There is mutual understanding of how our organization's program/services coordinate with the mental health services delivered through the Regional Health Authority.	47% 26 organizations	31% 17 organizations	22% 13 organizations
There are regular opportunities for informal contact/regular exchanges of information between staff in our organization and staff delivering mental health services through the Regional Health Authority.	47% 26 organizations	20% 12 organizations	33% 18 organizations

Other respondents, particularly those who rated their relationship poor or insufficient also noted that they have almost given up trying to establish a better working relationship. One respondent noted, *"Our relationship goes like this, they ask us for information about our views on mental health needs in the community, we tell them what is happening in the field, they go away, and then come back the next year to ask us the same question – we tell them the same information and then they go away. I don't see any changes to their programs and services, other than to restrict who can be served by their clinics. Yes we are all under funding pressure, but if you are not interested in using our information, don't ask. Or at least be up front and say that nothing can be done about it."*

Thirty-eight CBOs responding to the survey (62%) were not considered to be part of the mental health delivery system, even through they provided services to long-term mental ill

individuals, were called up to respond in crisis situations, or provided prevention information on mental health and mental illness. An Executive Director with a CBO noted, *"I've been employed by this organization for 15 years and even though many of our clients have mental health problems, maybe not diagnosed as mentally ill, I have never been able to get a meeting with the director of the mental health clinic to talk about how our organization could assist or what services could be provided – I have 'learned' that we are just not part of the 'system' so we are not really talked to."*

Gaps in Mental Health Services

Respondents described seven gaps in the mental health delivery system from their perspectives. As expected, funding for staffing mental health services was the number **one** gap (indicated by 54 organizations). One respondent noted, *"... a housekeeper in Regina earns 30% more that a mental health worker who should require no less than 2 years formal training".*

The **second** gap, reported by 50 organizations, was the need for on-going and specific public education, not just around the stigma of mental health/illness, but about:

- where are the resources in each community?
- what can be done?
- where is the place of first contact?

Many respondents felt that the approach of linking mental well-being to health promotion was only a start, but failed to account for the serious impact mental illness had on individuals, families and communities. One respondent provided an example of a client, "w*ho had a professional practice, wife, children, lovely home – a genuine nice guy – but fell into severe and persistent depression that no one around him recognized until everything fell apart. He now has nothing except for a once a week support group that may not meet much longer because there is no money for a facilitator – he's living in a small room in a hotel in the inner city. This is the life that we are holding out to the mentally ill?"* She also noted that if this individual's symptoms had been noted earlier by friends, family or co-workers an earlier intervention may have helped.

The **third** gap, reported by 47 organizations, was a continuing one of referrals, particularly what criteria were being used to refer someone to the formal mental health system. One respondent noted, "*the criteria seems to change – admittedly we don't make referrals every day, but at least once or twice a month and our staff seem to get different information each time."* Related to this gap was the need for a clear path to assess mental health services and a defined continuum of care.

The **fourth** gap, reported by 44 organizations, was the need for more qualified mental health workers – in addition to more psychiatric nurses, RNs with a strong background in psychiatric nursing, psychiatrists, and psychologists, there was the need for the 'in-between'. The trained worker who can recognize, respond, and stabilize a situation until the professionals could respond. This was particularly noted by CBOs in rural areas, where there were few professional mental health workers. Respondents indicated that because of the limited number of mental health workers in RHAs, long wait times were common which caused more problems for individuals and families.

Somewhat related to the need for more qualified mental health workers was the **fifth** gap reported by 41 organizations – the need for a broader crisis response approach (beyond the CBOs mandated to do so in Regina, Saskatoon and PA) – a crisis in a small community often will have a larger impact because the community is small and more people may be directly impacted by a suicide or violent situation. One respondent noted, *"Mental Health Services depend on CBOs in an emergency but don't seem to respect the CBO as an equal partner in the client's treatment or when the emergency is over."*

A **sixth** gap, reported by 35 organizations, was in services for specific audiences – particularly teenagers with specific mental health issues such as depression, FASD, or schizophrenia. Some of this will need to be addressed both by CBOs and RHAs, but CBOs also noted the need for schools and other community groups to be aware and involved. Many wanted to see specific mental health prevention/awareness and in-service programs throughout the K-12 system. Respondents identified that teachers in particular were often unaware of developing problems, particularly in teens or any community resources to help address them.

A **seventh** gap, reported by 34 CBOs, was the need for the province to have a long-term plan for mental health – a plan that was not based solely on an array of specific programs that were offered to varying degrees throughout the province. Many CBOs were confronted with trying to link their clients into programs, but were unable to explain what the long-term support or commitment would be for them. Was the purpose one of recovery, stabilization, or integration into the community or what? This discouraged families looking for support for their child or teenager as well as people who were already diagnosed with a mental illness.

Finally some direct comments from survey respondents about the role of CBOs:

> *I believe that CBOs are increasingly being called upon to deliver mental health services but are not funded or acknowledged in a way that supports this.*
>
> *CBOs are a valuable component in the continuum of services. We are cost effective and very responsive to the needs of our clients. Generally speaking I think we are valued and supported, but it is always a struggle to maintain the funding we need to keep the programs the community (and the formal mental health system) wants from us.*

Finally,

> *The role should not be a cheap alternative but rather a partner with a specialty and expertise. If we are continued to be viewed as a cheap alternative, in five to ten years many of us may not be here – then what?*

Conclusions from Survey Responses

The survey reached the target audience intended – specifically CBOs which provide mental health services, but may not be directly funded by Regional Health Authorities. The survey responses reflected not only a broad range of CBOs providing mental health services, but also provided views on the roles and needs of CBOs which fall outside of the HCOs/CBOs currently funded through RHAs.

The current role for CBOs responding to the survey involved counseling, assistance/referrals to other agencies, and education/promotion on mental health to both their clients and the public. Roles assumed by fewer CBOs involved providing residential services and vocational rehabilitation to long-term, persistent mentally ill individuals. Organizations providing these programs received a significant amount of their budget (up to 95% in some cases), from the RHA.

The number of staff involved in providing mental health services through CBOs responding to the survey is comparable to the number of mental health staff in Regional Health Authorities. There are a significant number of staff, as well as volunteers, delivering mental health services offered through CBOs. However, CBOs were confronted with challenges in both recruiting and retaining qualified staff which included:

- Non-competitive salaries particularly at a time when there is significant competition for qualified staff in many sectors, not just health and/or mental health, and
- Recruiting staff with the educational background required for the CBO environment – which was not always a university degree/professional designation. The work of many CBOs did not require a full complement of professional staff, but rather individuals who can work the 'front-line' directly with clients.

As well, the CBO funding environment was increasingly uncertain which compounded the recruitment and retention issues for these organizations.

Recruiting front line staff and succession planning were also identified as two of the top three challenges confronted by CBOs. Maintaining the current level of program and service delivery was ranked as the number one challenge. At the same time, program and service delivery was influenced by the ability to recruit and retain staff. These issues are not just specific to CBOs in the mental health sector but are also being experienced by organizations throughout the voluntary sector, influenced by an aging workforce, increased demands for public funding and increasing demands for service.

Defining appropriate qualifications for entry level positions was difficult. CBOs needed to achieve a balance between training required for professional staff (such as that required for a regulated profession) vs specific training in mental health. CBOs recognized that competition for professionals was high and with their current funding levels, working in a CBO was not attractive. At the same time, there was no program available in Saskatchewan that provided training for staff working as paraprofessional mental health workers in CBOs. Training was ad-hoc – provided through a variety of formal education programs (but not specializing in mental health), in-house sessions offered by the CBOs, as well as taking advantage of training opportunities offered through other organizations such as Regional Health Authorities.

While many CBOs had effective working relationships with RHAs, such relationships were often based on individual contacts rather than an organization-to-organization relationships. Such individual contacts were often broken if one of the individuals left their jobs. However, just as many CBOs indicated that they have a poor relationships with their RHAs with few opportunities to discuss mental health needs in their communities.

Gaps identified by survey respondents provided information on both the needs of CBOs (with the focus on recruiting appropriately qualified staff as well as funding to sustain program and service delivery) as well as gaps in services that needed to be address by both CBOs and Regional Health Authorities including:

- the need for public education as well as education targeted to specific audiences,
- general need in Saskatchewan for more qualified mental health workers including both professional and para-professional workers working in both the public and community based systems, and
- a provincial strategy for mental health which would provide the foundation for the work of all involved in developing and delivering mental health services and would offer a cohesive and consistent approach to mental health.

Key Informant Interviews

Current Roles

The first role cited by interviews with staff in CBOs is that of support – support for consumers and their families and support for the community in providing resources and education. For many of these CBOs, their mandate has expanded to fill gaps in their community, specifically around mental health issues. Cited most often was that the Regional Health Authority did not have a public education program to address mental health issues.

For CBOs (aka HCOs) who contracted specifically with Regional Health Authorities, their role was to deliver a specific service or group of services to specific individuals. The service usually pertained to social interaction, vocational rehabilitation/employment opportunities, and most critically housing support. Regional Health Authorities saw the role of the CBO as an extension of their services; services which were difficult for the Health Region to provide because of institutional limitations. Such limitations included long-term involvement with individuals who may need flexible/variable approaches to service delivery (and CBOs provided a cost effective and flexible way to deliver services). Mental Health and Addiction Services in Regional Health Authorities operate within institutional limitations. As such they generally cannot provide the flexibility needed because of both their mandate and staffing restrictions (such as working with a union environment which may limit changing job duties and tasks or adding positions quickly).

However, CBOs were very aware and constantly on-guard about being seen as an extension, or 'arm' of the Regional Health Authority. Having a good working relationship with the RHA was strived for and desired, but not at the cost of being an independent organization that could advocate for individuals and for issues that may contradict the direction of the government or the RHA.

Challenges

Unfortunately there was nothing new in the challenges with which CBOs were confronted – these included:

1. Resources, for both staff and funding, were minimally keeping up with the demands for service and the increasing cost of overhead – much of which was not covered through service contracts. In some cases the range of services or the

number of individuals served was being cut back by the CBO, although this was done as a last resort. Many CBOs noted that even a ½ time or one full-time position would allow them to connect their clients to existing opportunities, such as work/jobs, that were in the community – one interviewee noted that by '*... having one extra position to coordinate a work crew in the community, we could be providing work opportunities for 10 to 12 mentally ill adults who are currently sitting in their homes, usually alone, which is not anywhere near the ideal situation for someone with a mental illness – we have the work, and employers are willing to participate..*'

Many CBOs were also experiencing situations where they were be asked to offer a program from either a government department or a RHA, but with funding that only covered part of the cost, with the expectation that the CBO would contribute the rest of the funding. One interviewee noted, '*While the program seemed to be a good program, I'm not going to spend any of my staff or volunteer fundraising time to run a government program – I spend our fund raising dollars on programs that we are developing and targeted specifically to our primary target group. If the government wants us to run their programs, they need to come up with 100% of the funding – which I know will still be cheaper than if they tried to offer it directly.*"

At the same time, many interviewees acknowledged that mental health services through their health regions were being stretched to meet the needs or that funding seemed to have remained static for mental health. Many interviewees suggested that the priority placed on mental health services within the health region as well as within the Saskatchewan did not appear to be high.

2. Expectations from funders were not only remaining the same, but increasing. Some CBOs were pulling back from providing service without the corresponding funding being in place, but they knew that the service was not being picked up by other CBOs or by Regional Health Authorities – the clients were the ones that "*....really suffer and in many cases have setbacks that may return them to the streets or back into hospital.*"

3. Recruiting qualified staff was difficult; CBOs were in competition with other health employers, mainly Health Regions, but Health Regions were also having difficulty in recruiting/retaining staff. However because Health Regions were generally offering both better compensation, benefits, and working conditions ('*Why would a new graduate work for us at $27,000 a year when they can go to the health region and start at $10,000 a year more?*")[20] the effect on CBOs recruiting or retaining qualified staff was significant. The difference was not only in salary and benefits, but RHAs generally offered staff more opportunities for advancement and on-going continuing education, whereas most CBOs were relatively 'flat' organizations which few opportunities for advancement. However, interviewees also noted that while they could not provide advancement,

[20] The comment is a direct quote, however it may be likely the differential in salary is more than indicated by the interviewee.

the flexibility in developing and delivering programs and services was still a draw for many staff.

Closely related was the issue of retention; many CBOs were unable to keep new graduates for more than a year or two – one interviewee noted, *"I have trained practicum students in the hope that the CBO experience would encourage them to seek employment here – I know longer believe that – I probably have oriented new staff that the health district then hires – I should turn this CBO into a recruitment agency."*

4. With the limited pool of qualified professional staff, CBOs are moving towards paraprofessional staff, which generally had fewer qualifications than professional staff, as well as a more limited range of duties that they can be expected to perform. This concerned CBOs for a number of reasons – foremost was that the needs of the clients may be shortchanged and clients may not be getting the type of service that would help them progress. The role of professional staff was essential in monitoring and implementing programs, but more importantly in researching current best practices and developing approaches based on the most current research.

   The lack of professional staff also limited the organization's ability to respond to emerging issues or to advocate for policy changes. This type of work required individuals who have professional qualifications, and can keep up to date on new developments in the field and develop position papers and responses to emerging issues.

   Some CBOs have been able to retain qualified staff over the long term, but it was not because of competitive salaries – as one interviewee noted, *"I am very fortunate that I have an RN on staff who is willing to work part time, but then her husband is employed in a well-paying job – in effect he subsidizes her to work here – otherwise she would be working for the health district and even with casual employment would be earning more than she does here."*

   While professional staff were important to the long-term stability of CBOs, para-professional staff were also important in providing the front line, routine delivery of programs and services.

5. Staff training, both entry-level and continuing education, was an on-going issue at all staffing levels. This was driven by both limited dollars for continuing education as well as the availability of appropriate in-province training. CBOs found that many entry-level professionals did not have a clear understanding of the range of mental health issues, of available techniques or approaches to working with mentally ill clients or delivery systems at the community level. There was a steep learning curve for many new professionals working in CBOs, however as professionals there was some ability to adapt and expand their understanding – if they stayed with the CBO.

   While paraprofessional staff were becoming more common in CBOs, training paraprofessional staff was difficult as there was no Saskatchewan based program

which focused on mental health. Rather there was an array of diploma or certificate programs that may have included some information on mental health, but not enough to provide staff with the ability to work within the mental health system, particularly in the front line work of CBOs.

Few CBOs had developed in-house training programs – most training was ad-hoc and learning on the job – literally taking advantage of anything that came along. One organization was using an international program in psychosocial rehabilitation and supported staff who were interested in receiving certification in this approach. However it is not a condition of employment and the organization's resources were limited to support training and accreditation activities. A barrier to pursuing this approach further was no mental health framework in Saskatchewan that guided the development of services – making the case to the CBO's Board and to funders for more resources to support staff in obtaining the training and certification in psychosocial rehabilitation went generally unheeded.

Staff training in mental health was also compounded by the diversity of the CBOs which deliver mental health services – the diversity of CBOs included those providing residential services; vocational/rehabilitation; services to specific target audiences such as immigrants or domestic violence; promotion/prevention information; illness specific; individual counseling; services to individuals with addictions and mental health.

6. Many CBOs, whether funded directly by Health Regions for specific service delivery or by other government departments were involved in community-wide approaches to issues (such as community development approaches to address multiple issues such as hunger, employment, housing – all which impact on mental health clients). Time commitments limited their ability to become involved and choices were made on what to focus on and participate in. One interviewee commented, *"I know that my counterpart in the health district is probably at work until 6 or 7 at night returning phone calls, emails or preparing for the next morning's meetings, just as I am – the difference is that he is probably being paid $60,000/year whereas my salary is $38,400. Let's just say that my motivation is limited – unless it has a direct impact on my client group, I'm usually gone at 6 p.m.'* Another individual noted that as a CBO with a small staff numbers, *' I'm very cautious about becoming too involved in coalitions or other types of partnerships because it usually means that I'm away from the office and with no backup to do my work, it just means I do it during the weekend – yes I claim overtime, but I never really get a chance to take it –gee maybe I am just a volunteer here!'*

   However, these types of community-wide networks or coalitions are at the heart of what many of the government initiatives around building working relationships with the voluntary sector are about – creating the civil society and participating in the democratic process. CBOs and the voluntary sector provide the direct voice for many of the disadvantaged and unheard. In addition to staff and concerned volunteers, many CBOs have consumers or clients on their board or as volunteers delivering services. Contracted service delivery has become a priority because of

funding, but at the cost of hearing what the community needs and engaging governments in discussion around those issues.

7. Succession planning increasingly was a larger issue, particularly for CBOs with under 10 staff positions. These organizations generally did not have a wide pool of internal individuals to recruit from and external recruitment put them in direct competition with public organizations (such as RHAs) with better compensation, benefits and working conditions. In general, all staff, including senior staff in leadership positions, in CBOs were getting older and many will be retiring in the next 5 to 10 years.

   While current staff have developed working relationships in their community with a variety of organizations, have committed their career to working in the CBOs sector, and developed significant knowledge of the needs of clients/community, there was consensus that without significant infusion of resources, the knowledge and skills that currently exist would not likely be there in another decade. One senior staff person interviewed noted, *"I look at my existing staff and while all are capable of doing my job, I would not think for one moment of suggesting that they succeed me in my position when I retire – it is too much of a struggle now and will continue to be and I actually like my staff."*

Overall, the capability for human resource planning in CBOs is extremely limited. Almost none had specialized staff with human resource management training and relied on the Executive Director to provide this function – it was one more function that overworked senior staff were responsible for. Many interviewees admitted they did the minimum because of time and expertise – their focus was on the day-to-day rather than the longer term. They also questioned, given the current funding environment, if human resource planning was a worthwhile activity since their experiences suggested funding never matched the minimum human resource requirements of the CBO. In the same vein, training and continuing education, which should be a foundation for the growth and development of the CBO, was an ad hoc activity because of resources available within their organization and what was available within Saskatchewan.

Emerging Roles

Emerging roles for CBOs included providing prevention, promotion, information, and connecting people to the formal mental health system. For many CBOs this was always a focus of their mandate. However it was an activity that did not receive on-going funding support but rather project funding, which resulted in uneven implementation of programs.

The advantage that CBOs brought to this role included:

- Direct, in-the-field expertise with individuals that have experienced mental health issues; this breaks down barriers and stigma often associated with mental illness,[21]
- Many CBOs had connections to both provincial and national organizations as well as community-wide coalitions, and had access to programs that could be beneficial in prevention and promotion initiatives specific to mental health[22].

[21] Bradley, Benjamin,; Deighton, Judith and Selby Jane, 2004; *The 'Voices' Project: Capacity-Building in Community Development for Youth at Risk*, Journal of Health Psychology, 9;197

- CBOs were seen as 'honest brokers' who, because they represented and were accountable to the communities they served, were not seen to have an interest in promoting one approach over another.

One CBO indicated that they had been 'moved' in this direction when the RHA changed their delivery contract. While the adjustment period resulted in some challenges for the CBO, positive results were beginning to emerge. However, the funding provided to deliver the service was outpaced by the needs emerging in the community from the work of the CBO. The change also caused disruption to the clients that the CBO was previously delivering social/vocational services to – clients that may not be receiving a similar level of service from the RHA.

Challenges Encountered to the Emerging Role

Although the demand was there for increased prevention and promotion, it was difficult to provide the 'reach' that was often required (such as beyond a specific city/town) as the resources were not available. Sometimes the Regional Health Authority cooperated with a CBO to do joint presentations, but many CBOs indicated that there were usually seen as an add-on to the RHA's health promotion strategy. The most common area of cooperation was during Mental Health Awareness Week, but as one CBO stated, "*... one week out of the year is hardly going to make a dent in the needs, but we always hope that it will lead to more work with the health district.*'

Any funding was usually for short-term projects when a long-term, consistent strategy was needed (*"I will not develop one more program to offer to the community, only to have to withdraw it a year later because the funding is no longer there or where a need is addressed that can no longer be met – it doesn't do our reputation any good and in the long run, the community is left feeling more confused and isolated than before."*) Many CBOs noted the trend by governments to expect such programs to be self-sustaining over time, which CBOs felt was not only unrealistic, but unfair, "*... where else in our systems for delivering public services do we expect them to be self-sustaining?*"

Much of the prevention/promotion work was done with volunteers and CBOs were facing similar problems that CBOs throughout the voluntary sector were facing – volunteer demographics have changed (aging volunteers, competition for time, individuals working longer hours and not available, etc.) which limited the number of volunteers available. This was further complicated by limited staff available to coordinate and monitor the work of the volunteer group – again many CBOs stated it would be a ½ time or one full-time position which could '*rev up*' their prevention/information programs.

With the growing gap between the 'professionals' in institution-based mental health delivery and CBOs – it was difficult to create a 'common cause' approach when professionals take over (*"I don't' have the time to send my staff to a lot of professional training, and it results in our organization being at a disadvantage when we are talking with professionals in the health region about new developments or approaches that might be beneficial'.* Another interviewee noted "*... that in an area such as promotion – they have committed to their strategy and that is what is it going to be, even if it has little*

[22] Wells, Rebecca, Ford, Eric W. Et al, 2007; *Community-Based Coalitions' Capacity for Sustainable Action: The Role of Relationships*, Health Education & Behavior, 34:124

relevance to the dynamics in our community or to other approaches that we have found useful.'

In general, there was disappointment that there is no overall provincial strategy for mental health promotion/prevention or for delivering mental health services in general. Several interviewees mentioned the focus that *Project Hope* brought to addictions (which also resulted in some attention to the interaction between mental health and addictions). While there were concerns with the way *Project Hope* was being implemented, they recognized the benefits of focusing attention to a problem and providing additional resources to develop local strategies within a provincial framework. Some interviewees had hoped to see that with the release of Out of the Shadows[23], the province would not see the need to wait for a national strategy, as other provinces have moved ahead on revamping mental health services towards more community-based, consumer driven models.

Divergent Views on Collaboration

Both CBOs and the formal mental health system felt that collaboration was an important part of delivering mental health services. However, very different views on collaboration existed – Health Regions saw 'negotiating a contract' with a HCO/CBO as collaboration, while CBOs saw this activity as just part of their on-going relationship with the Health Region and not collaboration. In many instances there was networking/cooperation between CBOs within a community along with staff from RHAs' Mental Health Services and may have included participation of other government departments. Most often these connections were to share information on common clients and to ensure continuity of service for clients or address emerging issues that needed to be addressed. In some health regions such a system was 'standard operating practice'; in other health regions it was 'hit and miss', if done at all.

Informal networks and alliances also existed amongst different sectors within communities to address common community issues (including mental health). Many CBOs saw these networks/alliances as an important part of their work, with the goal to bring individuals and members of communities, agencies and organizations together in an atmosphere of support to systematically solve existing and emerging problems that could not be solved by one group alone. However, given available time, CBOs made choices in how much to participate and be involved in such initiatives. Many were also disillusioned about the direction of some initiatives; in that their voices were not heard and government based institutions often took control of the agenda to stress implementing their programs over meeting the needs of the community (*"I had some hope with the PVSI that there would be a shift in how these things are approached, but that seems to have fallen off of anyone's agenda and its back to business as usual."*)

Regardless of the differing views on collaboration, there were examples of effective working relationships between CBOs and Regional Health Authorities. Examples were given where Health Authorities were able to secure additional funding to support a new program or to address specific needs of a group of clients. However, these positive relationships typically involved individual-to-individual contacts between the RHA and

[23] Kirby, Michael; Keon, Wilbert;, 2006, *Out of the Shadows at Last – Transforming Mental Health, Mental Illness and Addiction Services in Canada*, Final Report of the Standing Senate Committee on Social Affairs, Science and Technology.

CBOs – usually based on a long-term relationship. Interviewees recognized that the relationship may not continue if one of the individuals moved on to another employment situation.

On the other hand, dealing with an institution-based organization, such as a Regional Health Authority also acted as a barrier to action – very often on simple things such as purchasing $200 or $300 worth of materials for a program to be delivered by existing staff in a CBO. Without the 'appropriate budget control' the money could not be spent and the materials could not be used off-site – the program never happened.

Many CBOs experienced a lack of clear communication, let alone collaboration with RHAs. For example a CBO described a situation where Mental Health Services were referring clients to the CBO for services they assumed were offered by the CBO. (*"I wondered why we were getting individuals asking to join our depression support group. After some further questioning I found out that they had been referred by the mental health clinic to us. We didn't have a program and had no money to begin one, even through there was clearly a need. In the end we worked it out with the clinic, but where was the knowledge, discussion and planning before hand? They should not have just made the decision that this is something we would offer without some form of consultation!).*

As governments move towards outcome-based results, expectations also arise that CBOs receiving funding from the government (and their agencies such as Regional Health Authorities) will move toward outcome-based results. However CBOs' capability to do so was extremely limited both by available staff to work on developing outcome measures, monitoring and collecting data, and reporting and using the results, as well as the expertise to do so. One interviewee suggested to the RHA that they would be more that willing to work with the RHA to jointly develop appropriate outcomes or even to just use the outcomes the authority had developed – the request was made over two years ago and *'... either they are not interested or don't have outcomes themselves, but we keep getting the hints that outcome measurement is looming and will be required soon as part of our contract.'*

The groundwork is there to support collaboration (such as regular meetings between organizations and a common cause to provide service to vulnerable individuals) however there is no long-term incentive to support efforts that move towards collaboration. At present the system involving CBOs was primarily a 'contract delivery/fee for service system' which was not designed to discuss issues, develop approaches or plan together for the future. When CBOs were requested to contribute information for discussion, they generally did not have the resources (staff with the skills and time to research position papers, etc.) to do so. This created frustration for both the formal mental health system as well as CBOs since it reinforced the status quo. If collaborative initiatives are deemed to be important, then the system must support and reward those organizations that work in a collaborative manner.

At the national level, the Canadian Collaborative on Mental Health Initiatives (CCMHI) has established both a framework for collaborative practice as well as fundamentals and

key elements for collaboration within mental health.[24] CCHMI has described an extensive range of best practices for collaborative mental health care. However few of these best practices involve CBOs and for the most part those that did, the CBO was a secondary player in the initiative. Although a small step in developing a collaborative relationship, those interviewed indicated that this was still an important first step to be included. In some cases, the rationale was often because of significant changes happening in the delivery system resulting in the formal system no longer able to deliver the level or scope of service it had previously.

A second focus of national initiatives around collaboration has been on inter-professional collaboration, starting at the entry level education of professionals. However, the main focus has been on developing inter-professional collaboration within a single workplace.[25] Again these are positive developments particularly from the perspective of the consumer of health (and mental health services). And if such initiatives continue, over time there should be a cohort of professionals for whom collaboration is the working norm. However it does not address the issue of organization to organization collaboration, or sector to sector collaboration such as the public sector (such as RHAs) and the voluntary sector (CBOs working in mental health).

While such national initiatives were good, few individuals interviewed were aware of the work of CCMHI and those that were indicated that they had little if any time to devote to reading the information let alone applying it; one interviewee indicated, *'I'm still trying to get around to reading the Conway Report sometime'*.

Current Status of Collaboration

From this study there was evidence of a range of community linkages that can move towards collaboration. Collaboration is a range of operating structures, beginning at networking, to cooperation/alliance, to partnership/coordination, to coalition and finally to collaboration (see Appendix 3 for an overview of the range of collaborative processes and the purposes, structure and processes involved in each).

In most instances the current status around collaboration between CBOs and the formal mental health system in Saskatchewan was networking (primarily to share information on the status of common clients) with some instances of cooperation and partnership (on limited projects). There was also evidence of cooperation among CBOs and other related organizations, such as through the work of the Mental Health Coalition. However the Coalition relies heavily on member organizations taking time from their own work as well as self-financing to meet and discuss issues – as indicated from interviews and from survey comments, many CBOs cannot release staff for this purpose and their budgets limit financial support to the coalition.

The level required for coalition and collaboration between CBOs (the voluntary sector) and government and their agencies (RHAs) requires a shift in thinking that was not currently evident in either government or the Regional Health Authorities. Organization to

[24] CCMHA, *What is Collaborative Mental Health Care: An Introduction to the Collaborative Mental Health Care Framework*, 2005

[25] Enhancing Interdisciplinary Collaboration in Primary Health Care Initiative, *The Principles and Framework for Interdisciplinary Collaboration in Primary Health Care*, 2005

organization collaboration is always difficult because it does require fundamental change in organizational policies and funding regulations. This is always difficult for government and their agencies. However, *Out of the Shadows* does support mental health delivery moving in this direction.

The mental health delivery system in Saskatchewan has, over time, focused on a 'program' delivery approach; Health Regions deliver a 'more or less' common set of programs and services, usually mandated by Saskatchewan Health with some variability depending on community needs. There are expectations and accountabilities from:

1. Government of Saskatchewan to Saskatchewan Health, and in turn from
2. Saskatchewan Health of Health Regions, and in turn from,
3. Health Regions to funded HCOs/CBOs.

While there was a desire to work a collaborative manner, the system currently does not support collaborative initiatives. The ability to re-structure delivery or to develop new joint programs appears to be extremely limited.

Conclusions from Key Informant Interviews

As with survey responses, the primary challenge faced by CBOs in fulfilling their current roles was the interplay between funding and human resource needs. Funding in the voluntary sector is an on-going issue, particularly when demands for delivery outpace the funding received by governments. However, funding also affects human resources within the voluntary sector. In the mental health voluntary sector, CBOs needed to achieve a balance between professional staff which can lead and grow the organization, but also a complement of paraprofessional staff which can deliver the programs and services. There were two major barriers to achieving this mix of human resources.

The first barrier was the limited funding accessible to CBOs which would allow them to provide comparable salaries to attract professionals to work in the voluntary sector. This is a major problem, as the workforce in CBOs was aging and within the next five to 10 years, there may be a significant changeover in senior staff in CBOs. At the same time, CBOs were competing directly for the same professionals with mental health services provided through the public sector.

The second barrier was the limited number of education/training programs that provided an adequate base of training around in mental health. While training/education programs in psychiatric nursing and to a lesser degree psychology and social work provide training for professional staff, interviewees did not see a comparable program for paraprofessional staff, and paraprofessional staff were increasingly becoming a mainstay of CBOs. The capability of CBOs do develop and deliver 'in-house' training varied – if the CBO had professional staff 'in-house' training could be supported – to a degree. However, there was no common approach. This was both because of the diversity of CBOs which provided mental health services – an immigrant settlement agency may need a different combination of skills and experiences, than a CBO providing residential services to long-term mentally ill individuals – as well as funding available for training.

Yet at the same time, without on-going sustainable funding to support positions, interviewees were doubtful that there would be the demand for developing and supporting an on-going education programs at a post-secondary education institution.

The central problem identified around collaboration was that while collaboration was generally seen as a positive working style, there were few incentives, rewards or operating structures for either CBOs or RHAs to participate in collaborative efforts. Particularly collaborative efforts that required sustained commitment of staff to develop and maintain the relationship at an organization to organization level. Funding was not in place to do so, and without funding, staff commitments were focused in other directions – specifically program/service delivery. This is the heart of the contradiction around implementing collaboration initiatives – it is seen as a way to improve program/service delivery, but collaboration cannot happen when the focus (funding) is almost solely on program and service delivery.

Post Secondary Education Programs

Training Programs

The Conway Report provided a detailed review of many of the strengths and weaknesses provided in professional training programs – this study does not intend to review or repeat Conway's findings. However Conway did note several programs, provided through SIAST that were relevant to caring for the mentally ill. These included:

- Home Care/Special Care Aide (now Continuing Care Assistant)
- Chemical Dependency Worker (now Addictions Counseling)
- Corrections Worker (now Correctional Studies)
- Early Childhood Education Worker
- Rehabilitation Worker
- Youth Care Worker

As well, courses from the Educational Assistant program were also included in the review. As the Occupational/Physical Therapist Assistant program was no longer accepting applications it was not included in the review.

As part of this study, curriculums from these courses were reviewed with specific attention to:

- Scope of the topic covered (for example mental health/illness one of many topics in a course or a single course focused specifically on mental health/illness),
- The relationship of the content to other course content, (specifically the focus on community-based organizations' role in provision of mental health service),
- Opportunities for a student to specialize in mental health and related illnesses, and
- Practicum opportunities to expand on the knowledge of participants.

In all of the programs there was at least one course with some reference to mental health/mental illness, however in most cases the course was a combination of many topics, of which mental health/illness was one. For example, at the certificate level:

- Continuing Care Assistant, (Special Needs – altered mental abilities, disruption in mental health), and a second course, Dementia Strategies
- Educational Assistant (Studies in Exceptionality B- behavioral disorders),
- Rehabilitation Worker (Studies in Exceptionality B – behavioral disorders, neurological disabilities, pervasive development disorders); Introduction to Services (for individuals with disabilities – not specifically mental illness)

- Youth Worker (Sociology B – issues facing mainstream and marginalized people in Canada); Behavioral Principles and Practices (guidelines for working with normal and exceptional children and youth.
- Early Childhood Education (Lifespan Development A – theories of learning and personality and the methods of studying human behavior); Family and Community Relations – identifying and applying techniques to support families will be emphasized).

At the diploma level, for Rehabilitation Worker and Youth Worker there is a requirement for a course on Suicide Intervention. The Youth Worker Diploma also requires two additional courses, Psychology B (which includes abnormal psychology, theories of emotional disturbance, treating emotional disturbance and altered states of consciousness) and Abnormal Psychology (which introduces a range of disorders often seen in youth at risk to expose the student to the behaviours likely to be encountered in the field).

At the diploma level for the Early Childhood Education, additional courses are required in Agency Visitation (examining community agencies that provide services to families with children who have challenging needs), Behavioral Principles and Practices (behavioral intervention strategies and their use in managing behavior) and two courses, Children with Diverse Abilities 1 and 2 (focusing on developmentally appropriate programming for young child with diverse abilities in inclusive settings).

Because the focus of both the Addictions Counseling Diploma and the Corrections Studies Diploma is very workplace specific, both diplomas focus on specific courses required for the workplace. However, the Addictions Counseling program does include:
- Concurrent Disorders Client (mental and psychiatric disorders that coexist with the chemically dependent client);
- Suicide Intervention, and
- Community Mobilization and Development (which is often at the centre of much of the work of CBOs)

In the Correctional Studies diploma relevant courses include:
- Abnormal Behaviour
- FASD Offenders
- Suicide Intervention

There were no core courses in mental health or mental illness offered through these programs, with the exception of the one credit course in Suicide Intervention at the diploma level. All the courses included mental health/mental illness as one aspect of a course covering a range of topics (one CBO noted that he had hired an individual from the Rehabilitation Worker Program specifically thinking that the individual would have some knowledge of mental illness, but was surprised that the individual was unaware of any aspect of mental illness). Practicum placements were usually very specific, particularly at the certificate level. However even at the diploma level there was little opportunity through practicums to develop a working application of mental health issues and the role of community based organizations which may support individuals, particularly adults, who are mentally ill.

At best mental health/mental illness was presented in post-secondary education certificates/diplomas as an array of courses that provided graduates with a glimpse of mental health and/or mental illness as well as some information on the services/systems available. As mental health and mental illness was not an uncommon health or human service issue, there should be the expectation that at a core group of courses be provided to graduates from any human service education programs.

Post secondary education programs appropriate to the staffing needs of CBOs are limited or non-existent. As noted in the Conway report, the depth of content and context on mental health/mental illness was limited, and usually with a focus on a medical model to present the content. In-depth content leading to skill development would not likely happen except at a university graduate level.

One of the difficulties that many post secondary education institution programs had was that they did not have tenured staff with expertise in the area to develop and/or monitor program/course content – reliance was on sessional instructors which limited the development of a cohesive approach. As well, there needed to be a defined labour market need to support both the cost of developing a program as well as offering the program. The example commonly used was the Chemical Dependency Worker program which addressed the specific needs of the sector along with a continuing labour market need.

Approaches to collaboration as an integral part of a workplace environment usually focused on developing inter-professional collaborative efforts. This focus was needed and was often difficult given differing perspectives on identifying, defining, addressing and solving a problem. There were many efforts underway to address inter-professional collaboration[26,27,28] but this may not benefit organization to organization collaboration which was needed to address community-wide social issues, such as mental illness.

While many professional programs and some paraprofessional training programs involved CBOs as practicum/work placement sites, the experience was usually not to develop an understanding of the role or perspective of the CBOs within a specific system. Rather the preference for CBOs as practicum sites was the flexibility that CBOs provided to the student in developing learning objectives and the front-line contact with clients. Unfortunately this rarely translated into the graduating student choosing to return to work in the CBO community as a career.

Options for Course Delivery

Some recent development may benefit CBOs, but not in the immediate future. The recent Government of Saskatchewan's budget included provision for a diploma program in psychiatric nursing through SIAST with a tentative start date of 2008 – if development goes according to plan, the first graduating class would be in 2010. However given the staffing shortages existing in almost all health regions, future graduating classes would likely be absorbed quickly into the formal mental health system. This would be further compounded by the continuing disparity between compensation offered at the CBO level.

---

[26] Newell, S. Susan; and others:, 1994 Collaboration in Interprofessional Practice and Training: An Annotated Bibliography, ED385101;

[27] Interprofessional Education Project, University of Toronto

[28] Best Practices – Canadian Collaborative Mental Heath Initiatives

Unfortunately given the reality of the funding squeeze confronting most CBOs, there will continue to be a mis-match between the needs for CBOs for staff who have the professional qualifications to inform practice or program development/delivery, and CBOs' ability to compensate them competitively.

CBOs have indicated that they want and need professional staff in order to:

- deliver and monitor a quality program for their clients,
- sustain their organization, and
- act as an advocacy voice for their clients,

However, their immediate need for qualified staff could be accommodated through a systematic program (such as a diploma in mental health studies which could, if needed, articulate to a degree). Many interviewees indicated the growth of the Addictions Counseling Diploma offered through SIAST and *"...wondered why addictions has the attention that mental health does not – mental health/illness affects as many and maybe more individuals at some point in their lives, but we are back to the stigma of being mentally ill, but apparently admitting to an addiction is now accepted"*.

Barring a full diploma program that focused on para-professionals' work in diverse CBOs delivering mental health services (which many expressed doubts would happen given the length of time it has taken for the province to support a Psychiatric Nursing program), an alternative would be a series of two to three day modules which staff could attend in-person or participate on-line to develop the range of knowledge and skills.

Conclusions from the Review of Training Programs

There is no cohesive education program on mental health/mental illness offered in Saskatchewan. Training is offered through a variety of programs leading to professional licensing – the most significant development was approval and funding to provide the Psychiatric Nursing program (with graduates anticipated in 2010). At the paraprofessional level the situation was even more disjointed with a number of certificates and diploma offering some content on mental health/illness, but with little focus on a specific approach or grounding in the existing mental health system in Saskatchewan.

Demand for any education/training is difficult to assess. While CBOs acknowledged the need for training, there were very few CBOs in a position to financially support staff to participate in continuing education opportunities. With uncertainty around year-to-year funding, many CBOs could not provide an estimate of current vacant positions, let alone future labour demands. Without secure and stable funding, it is even difficult to assess when a position is actually vacant. The working environment of a CBO consists of many temporary/contract positions dependent on project funding. It is also common in CBOs to re-shift work loads to other staff and/or volunteers if position funding is decreased. If funding is decreased resulting in the loss of a position, work may be reassigned to other staff and volunteers to maintain service delivery. Is the position then vacant if no funding is available? It is also difficult for CBOs to determine future workloads and the positions required to fill the work – again available funding is the major consideration. Overall, given uncertainties around funding CBOs are uncomfortable with promoting careers in mental health delivered through CBOs. This is a frustrating situation because they see the

need for both a public and CBO system to deliver mental health services in their communities, but there is no viable way to support and sustain the CBO system.

Discussion of Findings/Conclusions

Current Role and Status of CBOs

The current role for CBOs in the mental health delivery system has become that of service delivery organizations on a contracted basis, particularly for CBOs which are contracted directly by RHAs. While this is an essential role as it brings community based, responsive, and flexible services to individual clients in need, but it is not necessarily essential that a CBO deliver the contracted service. Any cost-effective and well-organized private sector organization could also provide the same service. Such is the case with private nursing and home care services. Except, private sector organization would not likely assume the contract because it would not cover the costs of delivering the service and there is limited ability for mentally ill individuals to pay for a private service – the default is to the voluntary sector through CBOs to provide these services.

The contracted service delivery role is done at the cost to many CBOs' original mandate and mission – typically advocacy. While one-on-one advocacy continues with specific clients to link them to needed services, this approach did not sustain or develop CBOs as organizations essential to the creation of a civil and democratic society over the long term. For example, while progress has been made to reduce the 'silo' effect between government departments particularly in providing service to common clients, the 'silos' still exist. CBOs, typically at a local level, have been able to act as a 'go-between' for clients between government departments to reduce the impact of conflicting department policies (such as on issues of earned income). CBOs see their strength as providing and accessing services for clients using a 'whole person' approach, however given the current focus on contract service delivery they are often prevented from doing so because revenues are for the delivery of specific programs or services. Work needs to be done at a province wide level to address many of these issues. However, that can only happen if CBOs have not only the opportunity and support to work together, but also access to the decision-makers in government to make change happen. Little of this work happens now because CBOs, their board members, staff and volunteers, are stretched to deliver on contracts.

Confronted by ever increasing demands and falling revenues, CBOs are beginning to 'let go' of programs and services in order to maintain existing staff and existing programs. The long term effects will likely be fewer and fewer programs offered by CBOs, with no assurance that other agencies or government departments will fill the gap. In fact, some CBOs reported that once they let a program go and even if a Health Authority indicated that they will offer it directly, the program is usually not or offered on a very restricted basis. The ultimate loser in this situation is the mentally ill individual who has an increasing limited range of programs and services available, and an increasingly limited involvement in their community.

Two forces are combining to jeopardize the future of CBOs in delivering mental health services – a workforce that is getting older and will be retiring soon (within the next 5 to 10 years) combined with salary and benefits that cannot compete with the public sector to replace existing or retiring staff. The expertise of many CBOs will disappear quickly if it cannot be replaced with a professional group of staff that sees a viable career working in the CBO sector – that will only happen if compensation issues are addressed. The existing benefits of working in the CBO community, such as flexibility, innovation, working directly with clients, and seeing immediate results will quickly be overtaken by the reality of earning a living wage.

Combined with an aging, but experienced workforce, and competition for staff, there is no 'in-province' training that is comprehensive enough for staff in CBOs delivering programs to mentally ill individuals. At best there are a few courses, in both professional (undergraduate) and paraprofessional programs, that cover mental health/mental illness. However the content delivery is usually as one of many topics which cover a wide range of problems that a target audience may have. Most CBOs are required to train the staff they recruit because there is little in the post-secondary education system that can assist in this area. Access to 'in-house' training offered through either RHAs or government departments, which could benefit staff in CBOs, is hit and miss.

As noted in the Conway report and through comments from organizations responding to the survey, there were large numbers of CBOs who delivered mental health services, but were not 'brought' into discussion about mental health directions. Conway particularly notes seniors and First Nations/aboriginal CBOs, but the survey also identified many organizations that commit over half of their organizations' focus to mental health issues for their clients – such CBOs include immigrant settlement agencies, domestic abuse organizations, and family service bureaus. A mechanism is needed to approach and include these organizations into discussions on the future of mental health services in the province. This is not a role alone for RHAs who are charged with delivering specific programs and primarily interact with specific CBOs/HCOs contracted to delivery those services. However there currently is no process to facilitate this.

The status of collaboration is primarily that of individuals in organizations that have developed working relationships – this sometimes extends to more formal networking amongst a variety of organizations – both CBOs and government departments/agencies on specific topics. But collaboration, both as a concept and as a working style, is poorly understood, but highly rated concept.

Emerging Needs and Roles for CBOs

If the funding and staffing issues in CBOs cannot be addressed, any role for CBOs in delivering mental health services in Saskatchewan will likely to diminish. Institutions will continue to offer care in the community, but any voice for the mentally ill, their families/friends, on the impact of having mentally healthy communities will be limited, because the essential element of the direct voice brought by CBOs through their role as advocates will no longer be there.

The role for CBOs in promotion/prevention on mental health and mental illness can be considerable – CBOs are ready to assume that role and can leverage, with minimal (but adequate) funding, volunteers and staff to provide coverage throughout the province. In conjunction with staff in RHAs, CBOs can provide a significant service in this area that provides a specific message on mental health and mental illness.

CBOs need to be able to work on collective actions and messages which support the advocacy mandate of community based organizations. This does not have to be an adversarial role, and in fact, good advocacy is the opposite. But advocacy is at the heart of why many community based organizations exist – not service delivery. Service delivery has overtaken the advocacy role because CBOs are seen by government as an efficient and effective way to delivery service – which they are. But one of the reasons they are effective at delivering programs and services is because they have a close and unique relationship with the community and individuals they serve. Advocacy informs service delivery and the service delivery experience informs advocacy – they cannot be separated.

Initial numbers from the survey suggest that there may be as many staff in CBOs delivering mental health services as there was in RHAs. This is a significant audience that requires, at the very least, on-going continuing education, which is difficult for many CBOs to provide 'in-house'.

Post secondary training for mental health workers needs to extend beyond the Psychiatric Nursing program currently under development. The program is needed, but competition for program graduates will outstrip the need for at least the next 3 to 5 years, if not longer. Besides not all staff in CBOs need to be Psychiatric Nurses – CBOs require a range of staff, including professionals and paraprofessionals from post-secondary human service programs in leadership, management and front-line delivery roles. But they all need at least some familiarity with mental health/illness and delivery systems. At present such training does not exist in a consistent and cohesive manner in Saskatchewan. Addressing training needs is also directly linked to the human resource needs in the sector. This is complicated by multiple factors. The range and diversity of CBOs that provide mental health services, and the reliance of any CBO sector on public funding creates a situation where it is difficult to determine future labour needs in the sector. There is no one organization, such as a professional association, that focuses on monitoring and identifying human resource and training needs for mental health workers in community based organizations.

Best Practices from the Sector

There are few best practices that emerged from the sector – in most cases the best practices were highly reliant on specific individuals promoting and sustaining the work. For example, the focus of one organization on supporting staff to receive training which could lead to certification in psycho-social rehabilitation may only continue as long as the current Executive Director continues. Given current funding levels, such a focus may be jeopardized by external influences.

There are good examples of where CBOs within a specific geographic location and a RHA are at the same table to meet and ensure that common clients are receiving services – sometimes the work extends to identifying emerging community needs. The widespread involvement of CBOs in such initiatives increases the likelihood that the work of the group can continue even if individuals change or organizations choose not to participate.

There are more examples of 'coping practices' – CBOs responding to external changes in their operating environment, for example withdrawals of an institution-based program leaving a gap in the service delivery, or program cutbacks upstream resulting in negative impacts on clients. They are best practices in the sense that programs and services continue to be delivered under adverse conditions – a trait of CBOs is that they can respond and adapt quickly. However these are not practices that should be modeled, as it does not use resource effectively and the outcomes cannot be planned.

Recommendations

1. **The province of Saskatchewan needs to develop a provincial strategy to address mental health and mental illness.**

   The impact of a provincial strategy on mental health and mental illness cannot be underestimated – the example of the provincial drug strategy is beginning to demonstrate that cohesive and focused attention to the problems and impact of drugs on Saskatchewan individuals, families and communities can have results. While developing a provincial drug strategy was made easier because of the existing Canada Drug Strategy, waiting for a national strategy on mental health is not necessary. As shown in *Out of the Shadows*, other provinces[29] have moved ahead without reference to a national strategy. Many of the key elements supporting person-centred recovery, community-based, and an integrated continuum of care are well-established concepts. For example, in Nova Scotia, standards for Mental Health Services are established and intended to 'guide quality service delivery and reduce variations across the province, while maintaining flexibility to adapt approaches to unique district, community and organization conditions'.[30]

   Only through a clearly articulated provincial mental health strategy can roles for key players, such as CBOs and agencies in the formal and voluntary sectors be identified, training/education be guided and influenced by the strategy, and promotion/prevention activities defined and delivered. At the same time a provincial strategy can also define a comprehensive service/access path by individuals in communities and agencies. As well, clear outcome measures can be articulated and progress measured.

   This recommendation goes beyond the scope of this study, but influences other recommendations of the study.

[29] Newfoundland, Quebec, Ontario, Alberta and British Columbia as noted in *Out of the Shadows at Last – Transforming Mental Health, Mental Illness and Addictions Services in Canada*, 2006; pp 93-96.

[30] Government of Nova Scotia, *Standards for Mental Health Services in Nova Scotia*, revised and approved, 2004.

2. **The primary role for CBOs should continue to be support and long-term rehabilitation/integration into the community for mental ill individuals.**

The supports provided are wide and varied including social interaction, meaningful work/employment, and secure and safe housing for adults with long term mental illness. Furthermore, CBOs are well-positioned as respected organizations both by their communities and by individuals receiving services. However, this role has become increasingly difficult to fill because funding has not kept pace with costs, particularly around staffing and compensation, as well as day-to-day operations and overhead. Many of the funding issues have been repeatedly identified in various reports on the voluntary sector, most recently the Blue Ribbon Panel on Grant and Contribution Programs. However, CBOs are not seeing action that leads them to a conclusion that the funding issues and conditions of contracts may change to support the work of the CBO rather than impose a regime of accountability.

3. **Advocacy roles of CBOs must be supported**

Advocacy at both an organization and sector level to government level is a key element in the role for CBOs. Restricting or discouraging this role does not benefit Canadian society. As focus is increasingly on service delivery the result, while unintended, has been a smaller role for advocacy Most CBOs are keenly aware of the difference between lobbying and advocacy. Governments have a role in ensuring that mechanisms exist and are supported o ensure that what CBOs need to say can be heard.

At the same time, there is a strong role for CBOs in providing individual advocacy for the mentally ill individual and his/her family – this is currently done, but usually at the cost of other work not been done. There are current programs within government (such as Victim Services from Saskatchewan Justice) which could serve as a model for such individual advocacy initiatives.

4. **Prevention/Promotion Services is an emerging role that CBOs should be actively involved in both developing and delivering.**

While Regional Health Authorities and Saskatchewan Health will have a lead role in prevention/promotion through Population Health Promotion, the expertise of the CBO sector cannot be ignored. As previously mentioned, their expertise and reach can extend far beyond what can be provided by RHAs.

CBOs need to be involved in creating the message and in delivering the message. This is not an 'add-on' to their existing work, but a new direction for which CBOs need to be funded to not only research best practices in promotion/prevention and develop the message, but to deliver it. Again, any CBO may only need a half-time or one full-time position to work in this area because they can access volunteers, families and most importantly consumers to assist in creating and delivering the service.

5. **Compensation for staff in CBOs must be addressed.**

6. **CBOs must be able to attract and retrain core professional staff**

These two recommendations are interlinked. The pressing need for most CBOs is being able to recruit and retain qualified staff – without increases in funding to address existing

compensation levels this will become increasingly harder. Any compensation study must consider:

- Equity between CBOs, but also equity with public health care employers.
- Equity does not imply the same compensation structure, but must acknowledge the disparity in compensation between the public sector and the voluntary sector in mental health and the impact it has on recruitment in the CBO sector.

While there are many are intangible benefits to working in the voluntary sector, there is a tipping point when the intangibles outweigh the ability to make a living wage or to choose working in the voluntary sector as a viable career option. This tipping point is close for many CBOs, particularly for those which have a limited capacity to fundraise or solicit donations to cover increasing operating costs, including salaries. Furthermore, there must be a mechanism to review compensation (and other funding issues) on a regular basis.

Closely linked to compensation, CBOs must have the ability to recruit core professional staff to sustain the work of CBOs and plan for their future (in such areas as advocacy, program development, working collaboratively with the public sector). Addressing compensation issues would allow CBOs to begin recruiting and retaining professional workers. Without professional staff that can conduct the research and advocacy to contribute to the development of a democratic, socially inclusiv society envisioned in governments in their voluntary sector initiatives, the role for CBOs will increasingly be restricted to contracted service delivery. The real possibility will be that those services will be limited to the ones that governments, through their public agencies, wish to deliver rather than the ones needed by the communities.

Professional staff bring to the organization, not only the ability to identify and articulate community needs to government, but also to ensure that quality standards for program development and delivery are maintained – the primary beneficiaries of that work are the mentally ill individual, their family/friends and the larger community.

Addressing compensation issues would also allow CBOs to recruit and retain the front line workers needed to deliver quality programs and services. Adequate compensation would also support workers to see that there is a career working in the mental health/CBO sector and would support individuals to seek preparatory training as well as continuing education.

7. Expectations of CBOs by governments must be funded fully.

The voluntary sector is often cited as being an efficient, effective and less expensive way to deliver service, but increases in overheads and program costs (not only compensation) are undermining the ability of CBOs to continue to deliver quality services. Surprisingly, most CBOs talked in terms having 1.5 positions (or less) which would enhance their programming reach. These are not organizations that are looking to add 10 or 15 new positions (however welcome that might be), but rather to have a few positions that can leverage the work of volunteers – for example committing 1 position to 20 organizations at $40,000/year is less than 1 million dollars/year to the provincial budget.

As well, government has a role in ensuring that if CBOs are expected to provide specific results (such as outcome measures) then there is also a role to provide the training that

will help them do so. This can best be done as training is rolled out to government and/or RHA staff who may be involved with measuring performance. Not only will the same message and approach be heard by all, it also provides an opportunity to develop common and relevant measures that both sectors can reference.

8. CBOs need support to sustain collective action

To create the civil society and democratic engagement envisioned by governments as a role for the voluntary sector means that governments must support the voluntary sector to meet, research, discuss, and present positions that can be considered by governments. This requires funding for CBOs to meet as coalitions of interested organizations to research and coordinate information to provide to governments and their agencies.

At times, the coalitions of interest may need to include CBOs beyond those who are traditionally seen as 'mental health CBOs'. There is the need to 'bring into the fold' organizations that have not traditionally been associated with as mental health CBOs (such as senior's organizations). The survey list begins to identify some of these organizations.

There will also be the need to mentor new CBOs to meet demands in the First Nation's/Metis/aboriginal communities. Most current CBOs would welcome working along side such organizations to help reach under-served target audiences.

At the same time, governments and their agencies must agree to meet on a regular basis to discuss options with such coalitions. Writing position papers is one activity, but the positions must be heard and understood by those who have the power to act. This may also mean that government will need to invest in training their staff on what collaboration is (and is not).

There are examples within the Saskatchewan government that supports the work of coalitions – for example through government funding was provided to CBOs in the Immigrant Settlement Sector which used the expertise of this sector to facilitate input into policy and program coordination for immigrants and refugees.

Structures already exist in the mental health sector that can facilitate and take a leadership role in sustaining collective action. For example, the Mental Health Coalition exists, but is limited because funding for meetings and other work of the coalition is dependent on the ability of its member organizations to take time from busy schedules to meet.

One of the areas that collective action needs to be supported is to address the on-going training and development needs as well as other human resource issues of staff within the CBO mental health sector. Currently there is no way to identify and monitor the human resource needs of this sector. While contracted studies provide some information, it is not an efficient way to provide this information on an on-going basis.

The decision to implement this recommendation is solely based on the value that the public sector places on the voluntary sector. If the voluntary sector is seen as contributing an important view and voice, then support should follow.

9. **A diploma level education program in mental health studies should be developed.**

While an ideal would see CBOs able to staff their organizations with range of professionals, that is simply not feasible (both financially as well as given the shortage of professionals required in the public system) nor is it necessary. The recently announced commitment by the provincial government to fund the psychiatric nursing program is a welcome start – however it is unlikely that CBOs will be able to recruit graduates from that program unless compensation issues are addressed over the long term. The pull to the public system will draw at least the first few graduating classes.

As well, not all staff in CBOs need to be psychiatric nurses – there are a range of jobs and positions required in CBOs; from the front line worker to program development to leadership.

A diploma or certificate program in mental health studies would address the increasingly use of paraprofessionals. There is no consistent training for this group – currently training ranges from no education in mental health to one or two courses providing some mental health content but within the context of another work environment (such as corrections). While this is an easy recommendation to make, the factors influencing the uptake for such a program are complex. Fundamentally the issue is sustainable funding which will allow CBOs to plan for their human resources and to create viable career options for individuals who wish to work in this sector of the mental health system.

There are potentially two target audiences for such a program – existing staff in CBOs that require continuing education and may also be interested in undertaking a credit program, as well as new staff that could be hired over the next 5 to 10 years as existing staff begin to retire and to accommodate existing turnover. One of the challenges in providing training to existing staff is that many are located throughout the province, but in small numbers in any location. This could be an ideal opportunity for RHAs, CBOs and post-secondary education institutions to develop short term courses, delivered using distance/on-line technology, which could meet the needs for continuing education but also provide elements from the proposed diploma.

As there currently is no program for preparatory training for this target audience in Saskatchewan, there are a couple of options to developing such an education program. In Saskatchewan the move to merge mental health services with addictions services is well established; as well some work is already underway to provide cross-training between mental health and addictions workers within Regional Health Authorities. It would make sense to include in the existing Addictions Counseling Diploma offered through SIAST a parallel stream of studies that focuses on mental health/mental illness. It is likely that core courses would include information on the following to provide sufficient understanding of the dynamics of mental health/illness:

- Common mental health conditions (symptoms, treatment, prognosis)
- Understanding mental health interventions and support strategies,
- Community resources (including the informal and formal mental health system),
- Mental health issues which examine society's approach to people with mental illness and the legislation that impacts people with mental illnesses,
- Role of family and community supports to aid people with mental illnesses, and
- Promotion/prevention strategies.

Further discussions with SIAST are required to identify the development and staff resources required to deliver such a program. It is likely that additional staff with specialized experiences in mental health delivery would be need to be recruited by SIAST. The benefit for using this option would be the ability to use an existing program to develop core skills but also to provide specialized courses. As well, as there is a close link between mental illness and addictions, individuals specializing in addictions counseling would benefit from wider availability of information around mental health issues.

A second option would be to develop a specific program that specializes in Mental Health Rehabilitation. This program could be linked to approaches such as psychosocial rehabilitation which could lead to certification as a Certified Psychiatric Rehabilitation Practitioner. To facilitate development, such a diploma could include courses or elements of courses developed for the psychiatric nursing program, as well as courses in existing certificate/diploma programs offered in human services. A third option would be to broker existing courses through post secondary institutions such as Bow Valley College or Grant MacEwan College in Alberta.

However it cannot be emphasized enough that without addressing the funding uncertainties within the CBO sector, it is unlikely that CBOs will be in a position to compensate and/or hire staff with upgraded education and skills specific to mental health. The consequence would be reduced enrollment in the program with eventual discontinuation of the program. The end result would be a return to the current situation.

Appendix 1: CBOs Receiving Survey

Aboriginal Family Services, Regina
AIDS Programs South Saskatchewan, Regina
AIDS Saskatoon, Saskatoon
Al Richie Community Association, Regina
Al Richie Health Action Centre, Regina
Alzheimer Society of Saskatchewan, Regina
Assault and Information Centre (SSAIC), Saskatoon
Athabasca Denesuline Family Service, Black Lake
Battleford District Food and Resource Centre, North Battleford
Battlefords Friendship Centre, North Battleford
Battlefords Interval House, North Battleford
Bethany Home, Saskatoon
Big Brothers and Big Sisters Association, Lloydminster
Big Brothers Big Sisters of Saskatoon, Saskatoon
Big Brothers of Regina, Regina,
Big Sisters, Regina
Buffalo Narrows Friendship Centre, Buffalo Narrows
CADAC Out-Patient Centre, Creighton
Canadian Paraplegic Association (Saskatchewan) Inc., Saskatoon
Carmichael Outreach, Regina
Catholic Family Services of Saskatoon (CFS), Saskatoon
Catholic Family Services of the Battlefords, Inc. North Battleford
Catholic Family Services, Prince Albert, Prince Albert
Catholic Family Services. Regina
Central Saskatchewan Family Resource Centre, Inc. Dundurn
Children's Haven Child Crisis Centre, Prince Albert
Christian Counselling Centre, Moose Jaw
Christian Counselling Services, Saskatoon
Circle Project Association Inc, Regina
CMHA Regina Branch
CMHA, Estevan
CMHA, Kindersley
CMHA, Moose Jaw
CMHA, North Battleford
CMHA, Prince Albert
CMHA, Saskatoon
CMHA, Swift Current
CMHA, Weyburn
CMHA, Yorkton
Community Action Cooperative, Regina
Community Family Resource Centre, Lestock
Core Community Association Inc, Regina
Cornwall Alternative School, Regina
Early Childhood Intervention Program, Regina
Edwards Society, Inc., North Battleford
EGADZ, Saskatoon
Ehrlo Community Services, Pilot Butte

Ekweskeet Healing Lodge, Onion Lake
Elizabeth Fry Society of Saskatchewan, Saskatoon
Epilepsy Regina, Regina
Family Service Bureau Inc., Moose Jaw
Family Service Regina, Regina
Family Service Saskatoon, Saskatoon
First Nations Network on Disabilities Inc, Saskatoon
Gary Tinker Federation for the Disabled, LaRonge,
Gemma House, Regina
Grace Haven, Regina
Hudson Bay and District Crisis Centre, Hudson Bay
Ile-a-la-Crosse Friendship Centre, Ile-a-la-Crosse
Immigrant Women of Saskatchewan (IWS), Regina
Immigrant Women of Saskatchewan, Prince Albert
Immigrant Women of Saskatchewan, Regina
Immigrant Women of Saskatchewan, Saskatoon
John Howard Society of Saskatchewan, Regina
Ka-Pa-Chee Centre, Fort Qu'Appelle
Kids Help Phone Saskatchewan Regional Office
Kikinahk Friendship Centre, La Ronge
La Loche Friendship Centre, La Loche,
Libbie Young Centre, Inc., Lloydminster
Lloydminster Interval Home Society, Lloydminster
Marguerite Riel Centre, Melfort
Metis Addictions Council of Saskatchewan Inc, Saskatoon
Mobile Crisis Services, Inc., Regina
Mobile Crisis Unit, Prince Albert, Prince Albert
Moose Jaw Food Bank, Moose Jaw
Moose Jaw Women's Transition House, Moose Jaw
Moose Mountain Friendship Centre, Carlyle
Native Coordinating Council Sundance Haven, Prince Albert
Native Co-ordinating Council, Prince Albert, Prince Albert
Neil Squire Foundation, Regina
North Central Community Association, Regina
North East Crisis Intervention Centre, Melfort
North West Friendship Centre, Meadow Lake
Partners for Rural Family Support, Humboldt
Peyakowak, Regina
Phoenix Residential Society, Regina
Piwapan Women's Centre, La Ronge, La Ronge
Planned Parenthood Regina, Regina
Portage Vocational Society, Inc., North Battleford
Prince Albert and District Community Service Centre, Prince Albert
Prince Albert Indian and Metis Friendship Centre, Prince Albert
Prince Albert Safe Shelter for Women, Prince Albert
Prince Albert Share-a-Meal Food Bank, Prince Albert

Qu'Appelle Haven Safe Shelter , Fort Qu'Appelle
Qu'appelle Valley Friendship Centre, Fort Qu'Appelle
Radius Community Centre for Education, Saskatoon
Rainbow Youth Centre, Regina
REACH, Regina
Regina Adult Learning Centre Inc., Regina
Regina Alternative Measures Program, Regina
Regina and District Food Bank, Regina
Regina Friendship Centre, Regina
Regina HELP, Regina
Regina Native Youth , Regina
Regina Open Door Society, Regina
Regina Senior Citizen's Centre, Regina
Regina Transition Women's Society, Regina
Regina Treaty & Status Indian Services, Regina
Regina Women's Community Centre, Regina
Regina Work Preparation Centre, Regina
S.H.A.R.E., Prince Albert
Safe Haven, Yorkton
Saskatchewan Seniors Mechanism, Regina
Saskatchewan Voice of People with Disabilities, Regina
Saskatchewan Women's Agricultural Network, Regina
Saskatoon Community Mediation Services (SCMS), Saskatoon
Saskatoon Council on Aging, Inc., Saskatoon
Saskatoon Crisis Intervention Service, Saskatoon
Saskatoon Food Bank and Resource Centre, Saskatoon
Saskatoon Housing Coalition, Saskatoon
Saskatoon Indian and Metis Friendship Centre, Saskatoon
Saskatoon Interval House, Saskatoon
Saskatoon Open Door Society, Saskatoon
Saul Cohen Family Resource Centre, Melville
SCEP Centre, Regina
Schizophrenia Society of Saskatchewan, Regina
Shelwin House, Yorkton
Smile Services, Inc., Estevan
Society for the Involvement of Good Neighbours, Yorkton
SOFIA House Inc., Regina
Souls Harbour Rescue Mission, Regina
South Saskatchewan Independent Living Centre, Regina
Southwest Crisis Services, Swift Current
Southwest Family Life Centre, Swift Current
Street Worker's Advocacy Project, Regina
Swift Current Friendship Centre, Swift Current
Tamara's House, Saskatoon
The FASD Centre, REGINA Community Clinic, Regina
The Oasis Center, Nipawin
Thunder Creek Rehabilitation Centre, Moose Jaw

Waskoosis Safe Shelter, Meadow Lake
Waterson Centre, Regina
West Central Crisis and Family Support Centre Inc., Kindersley
Wichihik Iskwewak Safe House Inc. Regina
Women of the Dawn Inc., Regina
YMCA, Regina
Yorkton Friendship Centre, Yorkton
YWCA of Regina, Regina
YWCA of Saskatoon, Saskatoon

Appendix 2: Survey

The Canadian Mental Health Association (Saskatchewan) is conducting research on the role of community-based organizations in providing mental health services in Saskatchewan. Our partners in this research are Saskatchewan Health and Saskatchewan Advanced Education and Employment. *INNOVA Learning* is conducting the research for us.

Community-based, voluntary organizations have a long history of providing mental health services in Saskatchewan. The scope and role of their services needs to be clearly described and articulated. The aim of this study is to provide information so that further discussion towards a framework and support can be defined.

The attached survey is intended to collect additional information on your organization's role in delivering mental health services, including issues around staffing. All information provided in the survey is **confidential** – your responses will be tabulated with other responses and no identifying information will be contained in any resulting reports.

Providing a definition of mental health can be difficult – for the purposes of this survey please use the following:

> *a mental health problem or illness refers to a variety of things* ***that change*** *an individual's thinking, mood, or behavior and* ***impairs*** *day-to-day living – such things may include depression, bipolar disorders, schizophrenia, anxiety disorders or phobias.*

We would like to ask for your cooperation in completing this survey. The survey can be:

1. Returned in the provided envelope

OR

2. Can be faxed to *INNOVA Learning*, Regina at 306-585-3017 **by FRIDAY, March 16, 2007**.

In case we need to contact you for further information, please complete the following:

Name of Person completing the survey: _____

Contact information: Phone: _____

Email: _____

For the purposes of this survey we are interested in community-based organizations (CBOs) defined as:

> *Independent organizations with a volunteer board of directors elected from the community; typically the CBO provides services, represents and advocates for the needs of a specific target audience. While the CBO may receive funding from government departments to deliver services, they do not exist only to deliver a service for government or related agents of governments; decisions regarding directions, programs and/or staffing are at the discretion of the CBO.*

Using this definition do you consider your organization a CBO:

- ❒ Yes
- ❒ No

1. Thinking about the range of services and programs your organization provides, how much of your organization's focus is on addressing mental health problems/issues of your clients:

   - ❒ 0 – 24% of our organization's focus
   - ❒ 25% to 49% of our organization's focus
   - ❒ 50% to 74% of our organization's focus
   - ❒ Over 75% of our organization's focus
   - ❒ We do not deliver programs or services pertaining to mental health

2. Describe the **three major roles** your organization undertakes in delivering mental health services:

   1. _____
   2. _____
   3. _____

3. In the last year. approximately how many individuals (such as clients or participants) did your organization deliver services to:

   _____

4. Indicate the number of paid staff positions in your organization (in the last year):

   Full-time (permanent) _____

   Part-time (permanent) _____

   Contract/project _____

5. Based on the staff listed in question 4, indicate the number of staff who spent a significant amount of their work time delivering mental health services in your organization during the last year.

   Full-time (permanent) _____

   Part-time (permanent) _____

   Contract/project _____

   5a. For the staff positions you listed above, please give their position titles or a brief job description.

6. We would like to get a sense of how staff positions in your organization are funded, **specifically those positions identified in question 5**. We recognize that positions are often funded through multiple sources, and for specific aspects of their work. However, considering all aspects of funding to sustain positions (including salary, benefits, overhead, program expenses), please indicate the **percentage** of funding your organization receives from the following sources to support the positions identified in question 5.

_____%	Federal government departments
_____%	Provincial government departments
_____%	Municipal governments
_____%	Regional Health Authorities
_____%	Community (foundations, corporations, etc.)
_____%	Fee for service (client and/or employer pays such as EFAP)
_____%	Self generated (donations, fundraising events)
_____%	Other (please describe _____)
100%	**TOTAL**

7. In the last year, indicate how volunteers in your organization contributed to the delivery of mental health services:

Number of volunteers _____

Number of volunteer hours _____

8. Using the following scales, indicate:

a. **Recruiting** staff with qualifications required by our organization is:

1☐ *2*☐ *3*☐ *4*☐ *5*☐
Difficult *Easy*

b. **Retaining** staff with qualifications required by our organization is:

1☐ *2*☐ *3*☐ *4*☐ *5*☐
Difficult *Easy*

9. Describe the three major problems your organization had has encountered in recruiting and/or retaining staff (please be as specific as possible):

1. _____

2. _____

3. _____

10. Given the scope and mandate of your organization, rank the importance of the following education/qualifications for entry-level staff (**with 1 (one) being the most important**)

_____ Master's degree in a mental health area

_____ Bachelor's degree in a mental health area

_____ Bachelor's degree in an related area, plus additional training in psychiatric rehabilitation.

_____ Diploma (two years) in a mental health area.

_____ Certificate (one year) in an related area with additional training in psychiatric rehabilitation

_____ High school diploma plus training in psychiatric rehabilitation.

_____ Other – please explain _____

11. From your top three choices for entry-level staff qualifications you identified in Question 10, describe any barriers your organization would have or has in recruiting individuals with these qualifications.

12. Using the following scales, please indicate the relationship your organization has with mental health services delivered through Regional Health Authorities.

There is open formal communication between our organization and the Regional Health Authority about mental health needs in our region.

1☐ *2*☐ *3*☐ *4*☐ *5*☐
Poor *Excellent*

There are opportunities to work collaboratively with the Regional Health Authority to develop programs to address mental health needs in our region.

1☐ *2*☐ *3*☐ *4*☐ *5*☐
Poor *Excellent*

There is a common commitment to address problems identified in delivering mental health services with the Regional Health Authority.

1☐ *2*☐ *3*☐ *4*☐ *5*☐
Poor *Excellent*

There is mutual understanding of how our organization's program/services coordinate with the mental health services delivered through the Regional Health Authority.

1☐ 2☐ 3☐ 4☐ 5☐
Poor *Excellent*

There are regular opportunities for informal contact/regular exchanges of information between staff in our organization and staff delivering mental health services through the Regional Health Authority.

1☐ 2☐ 3☐ 4☐ 5☐
Poor *Excellent*

Comments:

13. In the next five years, rank the following challenges that you anticipate your organization will need to address (with 1 (one) being the most challenging).

_____ Succession planning (replacing senior staff in our organization)

_____ Maintaining current level of program/service delivery

_____ Developing programs/services to respond to emerging mental health issues in our community

_____ Recruiting front line staff

_____ Developing advocacy positions to enhance mental health services

_____ Promoting knowledge about mental health to the public

_____ Using best practices to develop mental health programs and services

_____ Other – please describe

14. Describe gaps in mental health services and the impact these gaps have on clients, individuals, families and/or communities.

15. What other comments do you have on the role of CBOs in delivering mental health services in Saskatchewan (if you wish you can include additional pages).

Appendix 3: Range of Collaboration Initiatives

Community Linkages - Choices and Decisions

Levels	Purpose	Structure	Process
Networking	* Dialog and common understanding * Clearinghouse for information * Create base of support	* Loose/flexible link * Roles loosely defined * Community action is primary link among members	* Low key leadership * Minimal decision making * Little conflict * Informal communication
Cooperation or Alliance	* Match needs and provide coordination * Limit duplication of services * Ensure tasks are done	* Central body of people as communication hub * Semi-formal links * Roles somewhat defined * Links are advisory * Group leverages/raises money	* Facilitative leaders * Complex decision making * Some conflict * Formal communications within the central group
Coordination or Partnership	* Share resources to address common issues * Merge resource base to create something new	* Central body of people consists of decision makers * Roles defined * Links formalized * Group develops new resources and joint budget	* Autonomous leadership but focus in on issue * Group decision making in central and subgroups * Communication is frequent and clear
Coalition	* Share ideas and be willing to pull resources from existing systems * Develop commitment for a minimum of three years	* All members involved in decision making * Roles and time defined * Links formal with written agreement * Group develops new resources and joint budget	* Shared leadership * Decision making formal with all members * Communication is common and prioritized
Collaboration	* Accomplish shared vision and impact benchmarks * Build interdependent system to address issues and opportunities	* Consensus used in shared decision making * Roles, time and evaluation formalized * Links are formal and written in work assignments	* Leadership high, trust level high, productivity high * Ideas and decisions equally shared * Highly developed communication

Source: Community Based Collaborations- Wellness Multiplied, 1994, Teresa Hogue, Oregon Center for Community Leadership